

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) FRANK G. TRCKA				2. DATE OF DEATH MONTH February DAY 17, 1996 YEAR		3. TIME OF DEATH 1:45 A. M					
4. SOCIAL SECURITY NUMBER 217-34-4119		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 58 YRS.		7. DATE OF BIRTH (Month, Day, Year) Oct. 10, 1937		8. BIRTHPLACE (State or Foreign Country) Balto. Md.			
9a. FACILITY NAME (If not institution, give street and number) 400 Highmeadow Road				9b. CITY, TOWN OR LOCATION OF DEATH Reisterstown			9c. COUNTY OF DEATH Baltimore				
RESIDENCE OF DECEDENT											
10a. STATE Md.		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Reisterstown			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				
10e. STREET AND NUMBER 400 Highmeadow Road				10f. ZIP CODE 21136			10g. CITIZEN OF WHAT COUNTRY? USA				
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) — College (1-4 or 5+) 2 Years				18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Balto. City Police Dept.			16b. KIND OF BUSINESS/INDUSTRY Police Officer				
17. FATHER'S NAME (First, Middle, Last) Frank Trcka				18. MOTHER'S NAME (First, Middle, Maiden Surname) Helen Lachowski							
19a. INFORMANT'S NAME (Type/Print) Mrs. Bernadette M. Trcka				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 400 Highmeadow Road Reisterstown, Md. 21136							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Druid Ridge Cemetery 2/20/96			20c. LOCATION — City or Town, State Pikesville, Md.						
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Sam E. Eline</i>				22. NAME AND ADDRESS OF FACILITY ELINE FUNERAL HOME 11824 Reisterstown Rd. Reisterstown, Md. 21136							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>bronchogenic carcinoma</i> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST								Approximate interval Between Onset and Death 13 months			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>Howard Jacobs, Jr.</i>			29c. LICENSE NUMBER D28792		29d. DATE SIGNED (Month, Day, Year) 2/19/96		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Howard Jacobs, Jr. 20 CROSSROADS DR. #14 OWINGS MILLS, MD 21117											
31. DATE FILED (Month, Day, Year) FEB 21 1996				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>							

102.15 57





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04502

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Howard Taylor

2. Date of Death

February 17, 1996

3. Time of Death

12:06 pm

4a. Facility Name (If not institution, give street and number)

Northwest Hospital Center

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

115-10-0226

6. Sex

1 M 2 F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 31, 1915

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State  
MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

11 BRUBAR COURT #2B

10f. Zip Code

21207

10g. Citizen of What Country?

USA

11. Marital Status

1 Navar Married 2 Married  
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12TH GRADE

College (1-4 or 5+)

4 YRS.

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

ENGINEER

16b. Kind of Business/Industry

BYO RAILROAD

17. Father's Name (First, Middle, Last)

SAMUEL

TAYLOR

18. Mother's Name (First, Middle, Maiden Summa)

SADIE

WILLIAMS

19a. Informant's Name/Relationship (Type, Print)

STEWART TAYLOR

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9545 PAINTED TREE DR., RANDALLSTOWN, MD. 21133

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State  
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GARRISON FOREST CEMETERY 2-22-96 OWINGS MILLS, MD.

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

JOSEPH H. BROWN JR. FUNERAL HOME, P.A.  
1913 W. BALTIMORE ST., BALTIMORE, MD. 21223

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Coronary Artery Disease

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus  
Emphysema

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

1 Inpatient

2 Outpatient

3 DOA

Other:

4 Nursing Home

5 Residence

6 Other (Specify)

27. Manner of Death

1 Natural 2 Accident 3 Suicide 4 Homicide  
5 Pending Investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D27034

29d. Date signed (Month, Day, Year)

February 17, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. H. Cape Land MD 5310 Old Court Road Suite 201 Randallstown MD 21133

31. Date filed (Month, Day, Year)

FEB 21 1996

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

202206 21

96 04503

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>GEORGE THEODORE</b>				2. DATE OF DEATH MONTH <b>Feb</b> DAY <b>10</b> YEAR <b>1996</b>		3. TIME OF DEATH <b>8:15 pm</b>	
4. SOCIAL SECURITY NUMBER <b>216 10 2528</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>81</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>AUGUST 8, 1914</b>	
8. BIRTHPLACE (State or Foreign Country) <b>LOUISIANA</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Saint Joseph Medical Center</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Towson, Maryland</b>	
9c. COUNTY OF DEATH <b>Baltimore</b>				10. STATE <b>MARYLAND</b>			
10b. COUNTY <b>BALTIMORE</b>				10c. CITY, TOWN OR LOCATION <b>CARNEY</b>			
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>2915 Knoll Acres Road</b>			
10f. ZIP CODE <b>21234</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8 YRS.</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>SELF EMP. - owner</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Home Improvement Co.</b>			
17. FATHER'S NAME (First, Middle, Last) <b>JAMES M. THEODORE</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MARGARET C. NEUSTRETTA</b>			
19a. INFORMANT'S NAME (Type/Print) <b>JAMES M. THEODORE</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2915 Knoll Acres Road CARNEY, MARYLAND 21234</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>MOELLANO MEMORIAL PARK 8-14</b>		20c. LOCATION — City or Town, State <b>PARKVILLE, MARYLAND</b>		20d. DATE <b>8-14</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>[Signature]</b>				22. NAME AND ADDRESS OF FACILITY <b>EVANS CHAPEL OF MEMORIES 8800 HARBOR ROAD - PARKVILLE</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CEREBRAL VASCULAR ACCIDENT</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>MULTIPLE SYSTEM FAILURE FOLLOWING CORONARY ARTERY BYPASS</b> DUE TO (OR AS A CONSEQUENCE OF):  Approximate Interval Between Onset and Death <b>1 DAY</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>[Signature]</b>				29c. LICENSE NUMBER <b>H 43974</b>		29d. DATE SIGNED (Month, Day, Year) <b>Feb 10 96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR. ALICE HSIEH ST. JOSEPH MEDICAL CENTER</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 21 1996</b>				32. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 96 04504

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>KATHLEEN THOMPSON</b>						2. Date of Death Month <b>FEB.</b> Day <b>5</b> Year <b>1996</b>		3. Time of Death <b>9:15PM</b>										
	4a. Facility Name (If not institution, give street and number) <b>MERIDIAN BRIGHTWOOD</b>						4b. City, Town, or Location of Death <b>BROOKLANDVILLE</b>		4c. County of Death <b>BALTIMORE</b>										
Funeral Director	5. Social Security Number <b>577-18-5511</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>75</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>AUG. 20, 1920</b>		9. Birthplace (State or Foreign Country) <b>VIRGINIA</b>										
	Usual Residence of Decedent																		
10a. State <b>MD.</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>CARNEY</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
10e. Street and Number <b>3614 MELANIE ROAD</b>				10f. Zip Code <b>21234</b>		10g. Citizen of What Country? <b>U.S.A.</b>													
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>											
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 YRS</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOME</b>			16b. Kind of Business/Industry <b>HOUSEWIFE</b>												
17. Father's Name (First, Middle, Last) <b>EVERETT SEAY</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>REBY ALSOP</b>													
19a. Informant's Name/Relationship (Type, Print) <b>ROSE MARIE CLUGH</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3614 MELANIE ROAD CARNEY MD.</b>													
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>GATE OF HEAVEN</b>		20c. Date <b>2/8</b>		20d. Location - City or Town, State <b>MELHARRISBURG PENN.</b>												
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility <b>EVANS CHAPEL OF MEMORIES 8800 HARFORD RD. - PARKVILLE</b>													
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																			
<table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a. <b>Sepsis</b></td> <td>Due to (or as a consequence of):</td> <td rowspan="4">           Approximate Interval Between Onset and Death   <b>24 hours</b> </td> </tr> <tr> <td>b.</td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td>Due to (or as a consequence of):</td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. <b>Sepsis</b>	Due to (or as a consequence of):	Approximate Interval Between Onset and Death  <b>24 hours</b>	b.	Due to (or as a consequence of):	c.	Due to (or as a consequence of):	d.	Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. <b>Sepsis</b>	Due to (or as a consequence of):	Approximate Interval Between Onset and Death  <b>24 hours</b>																
	b.	Due to (or as a consequence of):																	
	c.	Due to (or as a consequence of):																	
	d.	Due to (or as a consequence of):																	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown											
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No											
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)													
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28a. Date of injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred										
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)												
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																			
29b. Signature and title of certifier 						29c. License number <b>D41614</b>		29d. Date signed (Month, Day, Year) <b>FEB 7, 1996</b>											
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>DR. ALLEN B. HALL 4000 OLD COURT ROAD - PIKESVILLE</b>																			
31. Date filed (Month, Day, Year) <b>FEB 21 1996</b>						32. Registrar's Signature 													

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28d show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be attached for use as the burial-transit permit.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>DOROTHY DELORES TRICE</b>				2. DATE OF DEATH MONTH DAY YEAR <b>FEBRUARY 20 1996</b>		3. TIME OF DEATH <b>3:50 AM</b>	
4. SOCIAL SECURITY NUMBER <b>215-09-2460</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>78</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>December 24, 1917</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>The Good Samaritan Hospital</b>				8b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		8c. COUNTY OF DEATH <b>N/A</b>	
9. RESIDENCE OF DECEDENT				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>	
10c. CITY, TOWN OR LOCATION <b>Rosedale</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>5707 Hamilton Avenue</b>	
10f. ZIP CODE <b>21237</b>				10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Year or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Bookkeeper</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Housing Construction</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Harry F. Lindauer</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Ida McKillop</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mr. Howard B. Trice</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5707 Hamilton Avenue Baltimore, Md. 21237</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Parkwood Cemetery 2/22/96</b>		20c. LOCATION — City or Town, State <b>Baltimore, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Mark T. Zavoyna</b>				22. NAME AND ADDRESS OF FACILITY <b>Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Md. 21214</b>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. RESPIRATORY FAILURE</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>b. USUAL INTERSTITIAL PNEUMONITIS</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c.</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d.</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HYPOXIC ENCEPHALOPATHY</b>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Anne Owen MB ChB</b>				29c. LICENSE NUMBER <b>P09303</b>		29d. DATE SIGNED (Month, Day, Year) <b>FEBRUARY 20 1996</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR ANNE OWEN, GOOD SAMARITAN HOSP, 5601 LOCH RAVEN BLVD, BALTIMORE MD 21237</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 21 1996</b>				32. REGISTRAR'S SIGNATURE <b>John A. ...</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 96 04506

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Marie Wanienele				2. Date of Death Month: 02 Day: 21 Year: 96				3. Time of Death 0705													
	4a. Facility Name (If not institution, give street and number) Solms Hopkins Bayview Med. Center				4b. City, Town, or Location of Death Baltimore				4c. County of Death N/A													
Funeral Director	5. Social Security Number 215-24-3747		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 67 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 28, 1928		9. Birthplace (State or Foreign Country) Maryland													
	Usual Residence of Decedent																					
To Be Completed by Funeral Director	10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Essex				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No													
	10e. Street and Number 214 Oak Avenue				10f. Zip Code 21221		10g. Citizen of What Country? U.S.A.															
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White														
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Assembler				16b. Kind of Business/Industry Box Manufacturer															
	17. Father's Name (First, Middle, Last) Henry Schiedt				18. Mother's Name (First, Middle, Maiden Surname) Maude Wakefield																	
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Sharon Holliday (Daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 214 Oak Avenue Essex, Maryland 21221																	
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gardens Of Faith Cemetery				20c. Location - City or Town, State Baltimore, Co.															
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Bruzdinski Funeral Home P.A. 1407 Old Eastern Ave. Essex, MD. 21221																	
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																					
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td>Sepsis</td> <td rowspan="4">Approximate Interval Between Onset and Death</td> </tr> <tr> <td>b.</td> <td>Immune Suppression</td> <td>3 days</td> </tr> <tr> <td>c.</td> <td>Renal transplantation</td> <td>4 weeks</td> </tr> <tr> <td>d.</td> <td></td> <td>4 weeks</td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)	a.	Sepsis	Approximate Interval Between Onset and Death	b.	Immune Suppression	3 days	c.	Renal transplantation	4 weeks	d.	
Immediate Cause (Final disease or condition resulting in death)	a.	Sepsis	Approximate Interval Between Onset and Death																			
	b.	Immune Suppression		3 days																		
	c.	Renal transplantation		4 weeks																		
	d.			4 weeks																		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Gastrointestinal bleeding Deep venous thrombosis left leg Retroperitoneal hematoma																						
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																			
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																					
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred													
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)																			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																					
	29b. Signature and title of certifier M.D.				29c. License number JTHW M5345		29d. Date signed (Month, Day, Year) 2/21/96															
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Glen S. Rosborough, Solms Hopkins Bayview Medical Center																					
State Registrar	31. Date filed (Month, Day, Year) FEB 21 1996				32. Registrar's Signature 																	

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Vashti Whitfield</b>				2. DATE OF DEATH MONTH DAY YEAR <b>February 17, 1996</b>		3. TIME OF DEATH <b>0941 A M</b>	
4. SOCIAL SECURITY NUMBER <b>217-20-6093</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>72</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>July 21, 1923</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>MERCY HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		9c. COUNTY OF DEATH <b>N/A</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>3319 INGLESIDE AVENUE</b>				10f. ZIP CODE <b>21215</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Health Care Provider</b>		16b. KIND OF BUSINESS/INDUSTRY <b>In Home</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Henry Henderson</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Estelle (Unknown) ESTELLE PERRY</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Barbara Rose</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>401 Morris Hill Rd., Glen Burnie, MD 21060</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>King Memorial Park 2/23</b>		20c. LOCATION — City or Town, State <b>Randallstown, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Leroy O. Dyett</b>				22. NAME AND ADDRESS OF FACILITY <b>LEREOY O. DYETT &amp; SON FUNERAL HOME 4600 LIBERTY HEIGHTS AVENUE 21207</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Septicemia</b> <b>Esophageal Carcinoma</b>							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>David L. M.D.</b>				29c. LICENSE NUMBER <b>P09133</b>		29d. DATE SIGNED (Month, Day, Year) <b>Feb 17, 1996</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DAVID BADAWI, MD Mercy Hospital, Baltimore, MD.</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 21 1996</b>				32. REGISTRAR'S SIGNATURE <b>John Davidson Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. The first part of the report is a general introduction to the subject.

2. The second part is a detailed description of the methods used.

3. The third part is a discussion of the results obtained.

4. The fourth part is a conclusion and summary of the work.

5. The fifth part is a list of references.

6. The sixth part is a list of figures and tables.

7. The seventh part is a list of abbreviations and symbols.

8. The eighth part is a list of acknowledgments.

9. The ninth part is a list of footnotes.

10. The tenth part is a list of appendices.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 96 04508

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>EMORY DARRELL WILLIAMS</b>					2. Date of Death Month Day Year <b>FEB 19, 1996</b>		3. Time of Death <b>7<sup>05</sup> PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>BAYVIEW MEDICAL CENTER</b>					4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>---</b>		
Funeral Director	5. Social Security Number <b>407-30-9108</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>68</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>SEPT 17, 1927</b>		9. Birthplace (State or Foreign Country) <b>Kentucky</b>	
	Usual Residence of Decedent									
10a. State <b>MD.</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>PARKVILLE</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>1420 DARTMOUTH AVE</b>					10f. Zip Code <b>21234</b>		10g. Citizen of What Country? <b>USA</b>			
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>---</b>					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>CLAIMS EXAMINER</b>			16b. Kind of Business/Industry <b>RAILROAD</b>		
17. Father's Name (First, Middle, Last) <b>BRENFORD WILLIAMS</b>					18. Mother's Name (First, Middle, Maiden Summa) <b>ETHEL SALYERS</b>					
19a. Informant's Name/Relationship (Type, Print) <b>ROSEMARIE DRONEBURG</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>408 MEADOW RD. BALTO. MD. 21206</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>AUBURNDALE MEM. PARK</b>		Data <b>FEB 26 1996</b>		20c. Location - City or Town, State <b>AUBURNDALE, FLA</b>			
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility <b>EVANS Chapel of Memories 2200 HARFORD Rd. Balto. Md 21234</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Dissecting Intravascular Coagulopathy</b> Due to (or as a consequence of): b. <b>Ventricular Fibrillation</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last									Approximate Interval Between Onset and Death <b>2 hrs.</b> <b>1 hr.</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
									24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					29b. Signature and title of certifier 		29c. License number <b>A4447357</b>		29d. Date signed (Month, Day, Year) <b>2/19/96</b>	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>C POUND BRADY UROLOGY INSTITUTE JHBH</b>										
31. Date filed (Month, Day, Year) <b>FEB 21 1996</b>					32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar

207255 25

1. The first part of the report is a general statement of the purpose of the study.

2. The second part of the report is a description of the methods used in the study.

3. The third part of the report is a description of the results of the study.

4. The fourth part of the report is a discussion of the results of the study.

5. The fifth part of the report is a conclusion of the study.

6. The sixth part of the report is a list of references.

7. The seventh part of the report is a list of appendices.

8. The eighth part of the report is a list of figures.

9. The ninth part of the report is a list of tables.

10. The tenth part of the report is a list of footnotes.

11. The eleventh part of the report is a list of acknowledgments.

12. The twelfth part of the report is a list of abbreviations.

13. The thirteenth part of the report is a list of symbols.

14. The fourteenth part of the report is a list of units.

15. The fifteenth part of the report is a list of definitions.

16. The sixteenth part of the report is a list of acronyms.

17. The seventeenth part of the report is a list of initialisms.

18. The eighteenth part of the report is a list of contractions.

19. The nineteenth part of the report is a list of abbreviations.

20. The twentieth part of the report is a list of symbols.

21. The twenty-first part of the report is a list of units.

22. The twenty-second part of the report is a list of definitions.

23. The twenty-third part of the report is a list of acronyms.

24. The twenty-fourth part of the report is a list of initialisms.

25. The twenty-fifth part of the report is a list of contractions.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04509

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>TODD PATRICK WOLINSKI</b>				2. Date of Death Month Day Year <b>FEBRUARY 14, 1996</b>		3. Time of Death <b>2:05 P.m</b>	
	4a. Facility Name (If not institution, give street and number) <b>8705 BAKER AVE</b>				4b. City, Town, or Location of Death <b>PARKVILLE</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>213 98 1054</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (in yrs. last birthday) <b>17</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>MARCH 25, 1978</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Md.</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Parkville</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>8705 BAKER Ave.</b>		10f. Zip Code <b>21234</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4or 5+) <b>→</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>STUDENT</b>		16b. Kind of Business/Industry <b>HIGH SCHOOL</b>				
17. Father's Name (First, Middle, Last) <b>Ronald L. Wolinski</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>PATRICIA A. HAMMEL</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Ronald L. Wolinski / father</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8705 BAKER Ave Balto. Md. 21234</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Green Mount Cemetery</b>		Date <b>FEB 20 1996</b>		20c. Location - City or Town, State <b>Balto. Md.</b>		
21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility <b>EVANS CHAPEL of MEMORIES 8800 Harford Rd. Balto. Md. 21234</b>						
23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Contact Gunshot Wound of Head</b> Due to (or as a consequence of):  b. _____ Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year) <b>2/14/96</b>		28b. Time of injury <b>1220 PM</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28d. Describe how injury occurred <b>self-inflicted gunshot wound</b>		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) <b>Home</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>8705 Baker Ave. Parkville, Md.</b>		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner		1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
29b. Signature and title of certifier <i>[Signature]</i> <b>Dennis J. Chute</b>		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>FEBRUARY 15, 1996</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dennis J. Chute</b> <b>111 Penn Street, Baltimore, Maryland 21201</b>								
31. Date filed (Month, Day, Year) <b>FEB 21 1996</b>		32. Registrar's Signature <i>[Signature]</i>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "Natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04510

1. DECEDENT'S NAME (First, Middle, Last) <b>Doris M. Weibe</b>				2. DATE OF DEATH MONTH DAY YEAR <b>February 14 1996</b>		3. TIME OF DEATH <b>1:15 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>214-01-8600A</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>81</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>May 12, 1914</b>	
8. FACILITY NAME (If not institution, give street and number) <b>North Arundel Hospital</b>				9a. CITY, TOWN OR LOCATION OF DEATH <b>Glen Burnie</b>		9b. COUNTY OF DEATH <b>Anne Arundel</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Anne Arundel</b>		10c. CITY, TOWN OR LOCATION <b>Pasadena</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>8208 Deerbrooke Ct.</b>				10f. ZIP CODE <b>21122</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b></b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Bindry Worker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Oscar T. Smith Co.</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Daniel W. Guerke</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Marie Kaline</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Marvin L. Weibe, Sr.</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8208 Deerbrooke Ct. Pasadena, Maryland 21122</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Glen Haven Mem. Park Feb. 17, 1996</b>		20c. LOCATION — City or Town, State <b>Glen Burnie, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>McCully Funeral Home 3204 Mountain Road Pasadena, Maryland 21122</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>INTestinal Volvulus</b> DUE TO (OR AS A CONSEQUENCE OF): a. <b>INTestinal Volvulus</b> b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST						Approximate interval between Onset and Death <b>1 month</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/></b>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>HOUSE PHYSICIAN</b>				29c. LICENSE NUMBER <b>D45455</b>		29d. DATE SIGNED (Month, Day, Year) <b>FEBRUARY 14, 1996</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>JOSHUA IMPERIO 301 HOSPITAL DRIVE GLEN BURNIE, MD 21061</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 21 1996</b>				32. REGISTRAR'S SIGNATURE 			

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Page 1

1. Introduction

The following text is a placeholder for the main body of the document. It contains several paragraphs of text that are mostly illegible due to the quality of the scan. The text appears to be a technical or scientific report, possibly discussing the properties of a material or the results of an experiment. The structure of the document suggests a formal report with a clear introduction, a main body of text, and a conclusion. The text is organized into paragraphs, with some lines starting with a number, indicating a list or a sequence of points. The overall tone is professional and academic.

2. Conclusion

The results of the study indicate that the material under investigation exhibits properties consistent with the theoretical predictions. Further research is required to fully understand the underlying mechanisms and to optimize the material for practical applications. The findings of this study provide a valuable contribution to the field and will be used to inform future research and development efforts.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				96 04511			
1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH				3. TIME OF DEATH			
EMMA ELIZABETH WEISMAN				Feb. 18, 1996				10:00 AM			
4. SOCIAL SECURITY NUMBER		5. SEX		6. AGE (In yrs. last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		7. DATE OF BIRTH	
218-03-2331		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		90 YRS.		MONTHS DAYS		HOURS MIN.		Jan. 25, 1906	
9a. FACILITY NAME (If not institution, give street and number)				9b. CITY, TOWN OR LOCATION OF DEATH				9c. COUNTY OF DEATH			
Greater Baltimore Medical Center				Towson				Baltimore			
RESIDENCE OF DECEDENT											
10a. STATE		10b. COUNTY		10c. CITY, TOWN OR LOCATION				10d. INSIDE CITY LIMITS?			
Md.		Baltimore		Timonium				1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER						10f. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?			
116 Welford Rd.						21093		U.S.A.			
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES?		13. WAS DECEDENT OF HISPANIC ORIGIN?		14. RACE — American Indian, Black, White, etc.					
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		Specify: White					
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		IF YES, GIVE WAR OR DATES		Specify:							
15. DECEDENT'S EDUCATION (Specify only highest grade completed)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY			
Elementary/Secondary (0-12) 7				College (1-4 or 5+) Home Maker				Own Home			
17. FATHER'S NAME (First, Middle, Last)						18. MOTHER'S NAME (First, Middle, Maiden Surname)					
William Vinyard						Adelaide Smyth					
19a. INFORMANT'S NAME (Type/Print)						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)					
Fredrica A. Krebs						224 Meadowvale Rd. Lutherville, Md. 21093					
20a. METHOD OF DISPOSITION				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)				20c. LOCATION — City or Town, State			
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State				Hilltop Service Corp. 2/19/96				Towson, Md.			
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)											
21. SIGNATURE OF FUNERAL SERVICE LICENSEE						22. NAME AND ADDRESS OF FACILITY					
						Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → BRAIN CANCER										Weeks	
a. DUE TO (OR AS A CONSEQUENCE OF):											
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST											
b. DUE TO (OR AS A CONSEQUENCE OF):											
c. DUE TO (OR AS A CONSEQUENCE OF):											
d. DUE TO (OR AS A CONSEQUENCE OF):											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											
PRIMARY HYPERTENSION											
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER?				26. PLACE OF DEATH (Check only one)							
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH				28a. DATE OF INJURY		28b. TIME OF INJURY		28c. INJURY AT WORK?		28d. DESCRIBE HOW INJURY OCCURRED	
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY		28b. TIME OF INJURY		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
				26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one)											
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER						29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year)			
Anthony Serrati						D37362		2/19/96			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)											
ANTHONY SERRATI M.D., 1205 YORK RD 32C LUTHERVILLE MD 21093											
31. DATE FILED (Month, Day, Year)				32. REGISTRAR'S SIGNATURE							
FEB 21 1996				Julia Davidson-Randall							

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04512

1. DECEDENT'S NAME (First, Middle, Last) WILLIAM ALLEN JR.				2. DATE OF DEATH MONTH DAY YEAR FEBRUARY 16 1996				3. TIME OF DEATH 3:37 P M			
4. SOCIAL SECURITY NUMBER 219 01 1928		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 76 YRS.		7. DATE OF BIRTH JAN. 1, 1920		8. BIRTHPLACE (State or Foreign Country) MARYLAND			
9a. FACILITY NAME (If not institution, give street and number) FORT HOWARD VETERAN HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH FORT HOWARD				9c. COUNTY OF DEATH BALTIMORE			
RESIDENCE OF DECEDENT											
10a. STATE MD		10b. COUNTY NA		10c. CITY, TOWN OR LOCATION BALTIMORE				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER 808 APPLETON STREET				10f. ZIP CODE 21217		10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1-11-43 10-26-45		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 12th College (1-4 or 5+) N/A				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SHIPPING CLERK		16b. KIND OF BUSINESS/INDUSTRY BOTTLING COMPANY					
17. FATHER'S NAME (First, Middle, Last) WILLIAM ALLEN SR.				18. MOTHER'S NAME (First, Middle, Maiden Surname) MATTIE HOPKINS							
19a. INFORMANT'S NAME (Type/Print) ELVA J ALLEN				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 808 APPLETON ST, BALTO MD 21217							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place) garrison forest veteran cemetery 22196		20c. LOCATION — City or Town, State OWINGS MILLS, MD							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Therese D. Harris</i>				22. NAME AND ADDRESS OF FACILITY MARCH FUNERAL HOME-WEST 4300 WABASH AVE. BALTO. MD 21215							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SEPSIS DUE TO (OR AS A CONSEQUENCE OF): URINARY TRACT INFECTION Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death 1 DAY 1 DAY			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE, CONGESTIVE HEART FAILURE, LEFT HEEL ULCER DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Mendoza</i>				29c. LICENSE NUMBER DO 9264		29d. DATE SIGNED (Month, Day, Year) 2-16-96					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) AMABLE MENDOZA, M.D., 9600 NORTH POINT ROAD, FORT HOWARD, MARYLAND 21052											
31. DATE FILED (Month, Day, Year) FEB 22 1996				32. REGISTRAR'S SIGNATURE <i>John A. Henderson</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

3E 04215

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04513

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ANITA L. AMEEN

2. Date of Death

FEB. 18, 1996

3. Time of Death

6:20 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital Tacoma Park

4b. City, Town, or Location of Death

4c. County of Death

N/A

5. Social Security Number

147-50-2866

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

39 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Dec. 30, 1956

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

New Jersey

10b. County

N/A

10c. City, Town or Location

Vineland

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

417 Wood St.

10f. Zip Code

08360

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Afro-American

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

unknown

16b. Kind of Business/Industry

unknown

17. Father's Name (First, Middle, Last)

unknown

18. Mother's Name (First, Middle, Maiden Summa)

Beatrice Lloyd

19a. Informant's Name/Relationship (Type, Print)

Rashad K. Ameen

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

417 Wood St. Vineland, New Jersey 08360

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Moriah Cem.

Date

2/23/96

20c. Location - City or Town, State

Phila. Pa.

21. Signature of Funeral Service Licensee

Joseph L Russ

22. Name and Address of Facility

Joseph L Russ F.H. 2222 W North ave Baltimore Md 21216

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SEPTICEMIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

DAYS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M. S. Nayar

29c. License number

D-17874

29d. Date signed (Month, Day, Year)

2-19-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. SANKARAN M. NAYAR - 3717 - 38th Ave. BRENTWOOD, Md. 20722

31. Date filed (Month, Day, Year)

FEB 22 1996

32. Registrar's Signature

John D. ...

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been completed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

81240 28



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04514

1. DECEDENT'S NAME (First, Middle, Last) <i>Paul Edward Adamski</i>				2. DATE OF DEATH MONTH <i>February</i> DAY <i>10</i> , YEAR <i>1996</i>		3. TIME OF DEATH <i>3:08 AM</i>	
4. SOCIAL SECURITY NUMBER <i>21-7-03-6661</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>76</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>March 8, 1919</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>7604 Spruce Road</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Dundalk</i>		9c. COUNTY OF DEATH <i>Baltimore</i>	
10a. STATE <i>Maryland</i>				10b. COUNTY <i>Baltimore</i>		10c. CITY, TOWN OR LOCATION <i>Dundalk</i>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER <i>7604 Spruce Road</i>				10f. ZIP CODE <i>21222</i>		10g. CITIZEN OF WHAT COUNTRY? <i>United States</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <i>WWII</i>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>10 Years</i> College (1-4 or 5+) <i></i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Supervisor</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Grain Elevator</i>	
17. FATHER'S NAME (First, Middle, Last) <i>Stephen Adamski</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Mary Bayus</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Mrs. Eveline R. Adamski</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>7604 Spruce Road Dundalk, Maryland 21222</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Garrison Forest V.A. Cem. 2/13/96</i>		20c. LOCATION — City or Town, State <i>Owings Mills, MD</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <i>Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, MD 21222</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Cardiopulmonary arrest</i>							
b. <i>Colon cancer, metastatic</i>							
c. <i></i>							
d. <i></i>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <i>hospice</i>					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature] for L. KLEINBERG</i>				29c. LICENSE NUMBER <i>D34934</i>		29d. DATE SIGNED (Month, Day, Year) <i>2/12/96</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>600 N. WOLFE ST. BALTO MD 21287</i>							
31. DATE FILED (Month, Day, Year) <i>Feb 22 1996</i>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

6-17

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

01240 38

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04515

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Grace M. Allman

2. Date of Death  
Month Day Year

February 20 1996

3. Time of Death

2:04 A.M.

4a. Facility Name (If not institution, give street and number)

1427 Locust

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

230 46 1325

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

58 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

July 4, 1937

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1427 Locust

10f. Zip Code

21226

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Quality Control

16b. Kind of Business/Industry

Glass Company

17. Father's Name (First, Middle, Last)

Loring Anderson

18. Mother's Name (First, Middle, Maiden Surname)

Adamaie Smoot

19a. Informant's Name/Relationship (Type, Print)

Jack D. Allman

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1427 Locust Baltimore, Maryland 21226

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metro Crematory, Inc.

Date

2/24/96

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Richard Gome

22. Name and Address of Facility

Gonce Funeral Home P.A.  
4001 Ritchie Highway Baltimore, Md. 2122523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Ovarian Cancer

Due to (or as a consequence of):

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

5 yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Breast Cancer

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Wm. C. Waterfield MD

29c. License number

S24356

29d. Date signed (Month, Day, Year)

Feb 20, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wm. C. WATERFIELD MD

St Agnes Hospital  
900 Caton Ave Balt Md 21229

31. Date filed (Month, Day, Year)

FEB 22 1996

32. Registrar's Signature

Julia Anderson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				96 04516							
1. DECEASED'S NAME (First, Middle, Last)				2. DATE OF DEATH				3. TIME OF DEATH							
EVELYN P. AHMUTY				FEBRUARY 20 1996				11:57 A M							
4. SOCIAL SECURITY NUMBER		5. SEX		6. AGE (In yrs. last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		7. DATE OF BIRTH		8. BIRTHPLACE (State or Foreign Country)			
235-36-5404		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		80 YRS.		MONTHS DAYS		HOURS MIN.		DEC. 9, 1915		WEST VIRGINIA			
9a. FACILITY NAME (If not institution, give street and number)						9b. CITY, TOWN OR LOCATION OF DEATH				9c. COUNTY OF DEATH					
UNION MEMORIAL HOSPITAL						BALTIMORE CITY				BALTIMORE CITY					
RESIDENCE OF DECEASED															
10a. STATE		10b. COUNTY		10c. CITY, TOWN OR LOCATION				10d. INSIDE CITY LIMITS?							
MARYLAND		ANNE ARUNDEL		ODENTON				1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER						10f. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?							
321 NEVADA AVE.						21113		UNITED STATES							
11. MARITAL STATUS		12. WAS DECEASED EVER IN U.S. ARMED FORCES?		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)				14. RACE — American Indian, Black, White, etc.							
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married		1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				Specify: WHITE							
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		IF YES, GIVE WAR OR DATES													
WW II															
15. DECEASED'S EDUCATION (Specify only highest grade completed)				16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY							
Elementary/Secondary (0-12) College (1-4 or 5+)				CLERK TYPIST				CIVIL SERVICE							
12															
17. FATHER'S NAME (First, Middle, Last)						18. MOTHER'S NAME (First, Middle, Maiden Surname)									
RICHARD RAY POWELL						ALTA NAOMI KIRKPATRICK									
19a. INFORMANT'S NAME (Type/Print)						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)									
VALERIE N. AHMUTY						650 S.W. 98TH TERRACE, PEMBROKE PINES, FL 33025									
20a. METHOD OF DISPOSITION				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)				20c. LOCATION — City or Town, State							
1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				CROWNSVILLE MD VET. CEM. FEB 26, 1996				CROWNSVILLE, MARYLAND							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE						22. NAME AND ADDRESS OF FACILITY									
						KIRKLEY-RUDDICK FUNERAL HOME 421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death			
IMMEDIATE CAUSE (Final disease or condition resulting in death) →												Immediate			
a. Massive Pulmonary Embolism															
DUE TO (OR AS A CONSEQUENCE OF):															
b. Right Pulmonary Thrombo-embolism												Immediate			
DUE TO (OR AS A CONSEQUENCE OF):															
c. S/P Aortic Valve Replacement												5 Weeks			
DUE TO (OR AS A CONSEQUENCE OF):															
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST															
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												24a. WAS AN AUTOPSY PERFORMED?		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
												1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>															
25. WAS CASE REFERRED TO MEDICAL EXAMINER?				26. PLACE OF DEATH (Check only one)											
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK?		28d. DESCRIBE HOW INJURY OCCURRED					
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined						M		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)								28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one)												29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year)	
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												D20856		FEB, 21, 1996	
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER															
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)															
JOHN A. WALSH, MD. 201 E. UNIVERSITY PKWY. BALTO. MD															
31. DATE FILED (Month, Day, Year)				32. REGISTRAR'S SIGNATURE											
FEB 22 1996															

2167

1950

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04517

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CHARLES EDWARD ASHBY

2. Date of Death

February 19 1996

3. Time of Death

7 20 PM

4a. Facility Name (If not institution, give street and number)

ST AGNES HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

216-16-4562

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

73 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

June 11 1922

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

801 Winters Lane Apt. 241

10f. Zip Code

21228

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: W W II13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
5

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Groomsman

16b. Kind of Business/Industry

Race Track

17. Father's Name (First, Middle, Last)

Hezekiah Ashby

18. Mother's Name (First, Middle, Maiden Surname)

Geneva Carroll

19a. Informant's Name/Relationship (Type, Print)

David G. Ashby (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

710 Maplehurst Lane Monkton, Maryland 21111

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metro Crematory Feb. 21, 1996

Date

20c. Location - City or Town, State

Catonsville, Maryland

21. Signature of Funeral Service Licensee

R. C. Witzke Jr.

22. Name and Address of Facility

Leroy M & Russell C Witzke Funeral Homes  
1630 Edmondson Avenue Catonsville, Maryland23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)e. METASTATIC MALIGNANT DISEASE TO Bone and 2 months  
Due to (or as a consequence of): LIVERSequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d.Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

SEVERE Anemia

LIVER HEMATOMA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Piece of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

SP [Signature], MD

29c. License number

P.O. 7537

29d. Date signed (Month, Day, Year)

February 19 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Simon MBOUDOU, MD SAINT AGNES HOSPITAL 900 Caton Ave, Baltimore MD 21229

31. Date filed (Month, Day, Year)

FEB 22 1996

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Filing, 735, item #7, 5 /1/96, cyw, per fh

1 - STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

96 04518

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <b>JAMES ANUSZEWSKI</b>				2. DATE OF DEATH MONTH <b>February</b> DAY <b>19</b> YEAR <b>1996</b>		3. TIME OF DEATH <b>10 18 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>212-09-0976</b>		5. SEX <b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>78</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>October 12 1918</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Henry Medical Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>City</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore City</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1908 Bank Street</b>				10f. ZIP CODE <b>21231</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WWII</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b></b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Bethlehem Steel</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Lift Truck Operator</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Joseph Anuszewski</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Lena Lentz</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Frances LoBianco</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8204 Boman Court Baltimore, MD 21204</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>St. Stanislaus Cemetery 2/24/96</b>		20c. LOCATION — City or Town, State <b>Baltimore, Maryland</b>		20d. DATE <b>2/24/96</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Elizabeth Selinski</b>				22. NAME AND ADDRESS OF FACILITY <b>Lilly &amp; Zeiler, Inc. Funeral Home 1901 Eastern Avenue Baltimore, MD 21231</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Sepsis</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Pneumonia</b> <b>Hypertension</b>							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Renal Insufficiency</b> <b>Intracranial Subdural hematoma</b> <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>DAVID A BLAKE, MD</b>				29c. LICENSE NUMBER <b>PO 9124</b>		29d. DATE SIGNED (Month, Day, Year) <b>February 19, 1996</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Henry Medical Center 301 St Paul St Baltimore, MD 21202</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 22 1996</b>		32. REGISTRAR'S SIGNATURE <b>John Davidson</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

68760

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

5+1

01270 1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Film G732 item 1 2-22-96 rja

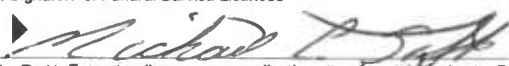
Certificate of Death

Reg. No. 96 045119

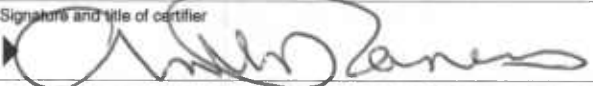

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) <b>IVA MAE BAILEY</b>				2. Date of Death Month <b>FEB</b> Day <b>20</b> Year <b>1996</b>		3. Time of Death <b>6:10 P</b>	
4a. Facility Name (If not institution, give street and number) <b>HARBOR HOSPITAL CENTER</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>	
5. Social Security Number <b>215-28-4142</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>62</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>06/11/1933</b>	
9. Birthplace (State or Foreign Country) <b>MARYLAND</b>		10a. State <b>MARYLAND</b>		10b. County <b>ANNE ARUNDEL</b>		10c. City, Town or Location <b>SEVERN</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>1437 SEVERN ROAD</b>		10f. Zip Code <b>21144</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>N/A</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>MACHINIST</b>		16b. Kind of Business/Industry <b>TOOL INDUSTRY</b>		17. Father's Name (First, Middle, Last) <b>FERRIS ELMER HOOD</b>	
18. Mother's Name (First, Middle, Maiden Surname) <b>ANNIE MARIE SCHULTZ</b>		19a. Informant's Name/Relationship (Type, Print) <b>JOHN WESLEY BAILEY</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1437 SEVERN ROAD, SEVERN, MARYLAND 21144</b>		20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>ENTOMBMENT</b>	
20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MEADOWRIDGE MEMORIAL PK.</b>		20c. Date <b>2/23/96</b>		20d. Location - City or Town, State <b>ELKBRIDGE, MARYLAND</b>		21. Signature of Funeral Service Licensee 	
22. Name and Address of Facility <b>SINGLETON FUNERAL HOME</b>		22. Name and Address of Facility <b>1 SECOND AVENUE S.W., GLEN BURNIE, MD 21061</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. HEMORRHAGE</b> Due to (or as a consequence of): <b>b. AORTIC ANEURYSM</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>CHRONIC PULMONARY DISEASE</b>		Approximate Interval Between Onset and Death <b>2 HRS</b> <b>UNKNOWN</b>	

To Be Completed by Physician/Medical Examiner

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CORONARY ARTERY DISEASE</b> <b>HYPERTENSION</b> <b>CHRONIC PULMONARY DISEASE</b>				23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
29b. Signature and title of certifier 		29c. License number <b>D16381</b>		29d. Date signed (Month, Day, Year) <b>FEB 21, 1996</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ANTHONY J. RANE M.D.</b> <b>3601 S. HANOVER ST.</b> <b>BALTO, MD 21225</b>	
31. Date filed (Month, Day, Year) <b>FEB 22 1996</b>		32. Registrar's Signature 		33. Registrar's Title <b>Registrar</b>		34. State Registrar <b>20</b>	

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

01800 24

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Per fh

Film G732 item 1 2-22-96 rja

## Certificate of Death

Reg. No. 96 04520

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Elijah J. Brown, Jr.</b>				2. Date of Death Jr Month <b>February</b> Day <b>14</b> Year <b>1996</b>				3. Time of Death <b>11:00 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Northwest Hospital</b>				4b. City, Town, or Location of Death <b>NI A</b>				4c. County of Death <b>Balto</b>	
Funeral Director	5. Social Security Number <b>215-40-4491</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs, last birthday) <b>54</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>July 5, 1941</b>		9. Birthplace (State or Foreign Country) <b>md</b>	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>md</b>		10b. County <b>Balto</b>		10c. City, Town or Location <b>Randallstown</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>3614 Yennar Lane apt 2B</b>				10f. Zip Code <b>21244</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
	15. Decedent's Education (Specify only highest grade completed) <b>12th Elementary/Secondary (0-12)</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>4 yrs Chemist</b>		16b. Kind of Business/Industry <b>Treatment Plant.</b>			
	17. Father's Name (First, Middle, Last) <b>Elijah J. Brown Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Daisy Knotts</b>					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Doreen Brown-wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3614 Yennar Lane apt 2B Balto, md 21244</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>King Memorial Pk</b>		20c. Date <b>2/24/96</b>		20d. Location - City or Town, State <b>Randallstown, md</b>			
	21. Signature of Funeral Service Licensee <b>Gabrielle Cook</b>				22. Name and Address of Facility <b>March F. H-west 300 Wabash Ave</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Metastatic Adenocarcinoma of Colon</b> Due to (or as a consequence of):  Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>									
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide										
28a. Date of Injury (Month, Day, Year)										
28b. Time of Injury <b>M</b>										
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No										
28d. Describe how injury occurred										
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)										
28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <b>Marshall A. Levine</b>										
29c. License number <b>D17873 (Maryland)</b>										
29d. Date signed (Month, Day, Year) <b>2/24/96</b>										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Marshall A. Levine 4000 Old Court Rd. Suite 306 Baltimore, MD 21208</b>										
31. Date filed (Month, Day, Year) <b>FEB 22 1996</b>										
32. Registrar's Signature <b>John A. Russell</b>										

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 21 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital certifying Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filed with the funeral director, page 2 should be detached for use as the burial-transit permit.

12 01250

*[Faint, mostly illegible text covering the majority of the page, possibly bleed-through from the reverse side.]*

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				96 04521			
CERTIFICATE OF DEATH				REG. NO.							
1. DECEDENT'S NAME (First, Middle, Last) <i>Dorothy Bowen</i> DOROTHY L. BOWEN				2. DATE OF DEATH MONTH DAY YEAR <i>JAN 30 1996</i>				3. TIME OF DEATH <i>4:20 P M</i>			
4. SOCIAL SECURITY NUMBER <i>522-12-7656</i>		5. SEX <i>1 M 2 X F</i>		6. AGE (In yrs. last birthday) <i>88</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>Dec. 20, 1907</i>		8. BIRTHPLACE (State or Foreign Country) <i>Indiana</i>			
9a. FACILITY NAME (If not institution, give street and number) <i>Holy Cross Hospital</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Silver Spring</i>				9c. COUNTY OF DEATH <i>Montgomery</i>			
10a. STATE <i>Maryland</i>				10b. COUNTY <i>Montgomery</i>		10c. CITY, TOWN OR LOCATION <i>Silver Spring</i>		10d. INSIDE CITY LIMITS? <i>1 YES 2 X NO</i>			
10e. STREET AND NUMBER <i>901 Arcola Avenue</i>				10f. ZIP CODE <i>20902</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					
11. MARITAL STATUS <i>1 NEVER MARRIED 2 MARRIED 3 X WIDOWED 4 DIVORCED</i>		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <i>1 YES 2 X NO</i> IF YES, GIVE WAR OR OATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <i>1 YES 2 X NO</i>		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>Elementary/Secondary (0-12) 12th grade</i>				15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Secretary</i>		15b. KIND OF BUSINESS/INDUSTRY <i>Military</i>					
17. FATHER'S NAME (First, Middle, Last) <i>Alpha Buickle</i>				16. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Katherine McMullen</i>							
19a. INFORMANT'S NAME (Type/Print) ( <i>niece</i> ) <i>Katherine Boyle</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>19804 Meredith Drive-Derwood, Maryland 20855</i>							
20a. METHOD OF DISPOSITION <i>1 BURNED 2 CREMATION 3 REMOVAL FROM STATE 4 X DONATION 5 OTHER (Specify)</i>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		DATE		20c. LOCATION — City or Town, State					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ronald S. Wade, Dir.</i>				22. NAME AND ADDRESS OF FACILITY <i>State Anatomy Board-655 W. Baltimore Street Rm. B026-Baltimore, Maryland 21201-1559</i>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Wheezing</i> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>degeneration</i>								24a. WAS AN AUTOPSY PERFORMED? <i>1 YES 2 X NO</i>		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <i>1 YES 2 X NO</i>	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <i>1 YES 2 X NO</i>				26. PLACE OF DEATH (Check only one) HOSPITAL: <i>1 Inpatient 2 ER/Outpatient 3 DOA</i> OTHER: <i>4 Nursing Home 5 Residence 6 Other (Specify)</i>							
27. MANNER OF DEATH <i>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</i>				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <i>1 YES 2 NO</i>		28d. DESCRIBE NOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <i>1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</i> <i>2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</i>											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Myron L. Lenkin MD</i>				29c. LICENSE NUMBER <i>DD6674</i>				29d. DATE SIGNED (Month, Day, Year) <i>1/31/96</i>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>MYRON L. LENKIN 2309 FOREFIELD RD WHEATON MD</i>											
31. DATE FILED (Month, Day, Year) <i>FEB 22 1996</i>				32. REGISTRAR'S SIGNATURE <i>John Andrew Randall</i>							

153-20



Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)

CLARENCE BRISCOE

2. Date of Death

Month Day Year  
FEB. 19, 1996

3. Time of Death

1933PM

4a. Facility Name (If not institution, give street and number)

1607 BAKEBURY COURT

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

5. Social Security Number

218-56-1671

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

43 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year  
2-19-96

9. Birthplace (State or Foreign Country)

Baltimore

Usual Residence of Decedent

10a. State

Maryland

10b. County

10c. City, Town or Location

Baltimore City

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

1300 Divison Street

10f. Zip Code

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

Unknown

Unknown

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Unknown

16b. Kind of Business/Industry

Unknown

17. Father's Name (First, Middle, Last)

Unknown

18. Mother's Name (First, Middle, Maiden Surname)

Naomi Briscoe

19a. Informant's Name/Relationship (Type, Print)

Naomi McGee

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1300 Divison Street, Baltimore, Md.

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Zion Cemetery

Date

2/24/96

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Irvin P. Carroll

22. Name and Address of Facility

Irvin P. Carroll Funeral Home  
1712 W. North Ave, Baltimore, Md. 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. NARCOTIC INTOXICATION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☒ Could not be determined

28a. Date of Injury (Month, Day Year)

2/19/96

28b. Time of Injury

7:33 PM

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

FOUND AT FRIEND'S HOUSE

28d. Describe how injury occurred

SUBJECT WAS FOUND UNRESPONSIVE

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1607 BAKEBURY CT. BALTIMORE, MD. 21217

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) as stated.

29b. Signature and title of certifier

Irvin P. Carroll

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

FEBRUARY 20, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

H. A. Bryson D. K. Brown MD. 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

FEB 22 1996

32. Registrar's Signature

Julia Davidson-Randall

State Registrar

SS200 26

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04523

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

FAN

BUCKNER

2. Date of Death

Month Day Year  
FEBRUARY 18, 1996

3. Time of Death

10:20pm

4a. Facility Name (If not institution, give street and number)

3409 OLD POST DRIVE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

217-05-1944

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

JULY 14, 1912 MARYLAND

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3409 OLD POST DRIVE

10f. Zip Code

21208

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

GERSHON

BELAGA

18. Mother's Name (First, Middle, Maiden Surname)

ANNA

TZOLITEREFSKI

19a. Informant's Name/Relationship (Type, Print)

MR. CHARLES HEYMAN (NEPHEW)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3409 OLD POST DRIVE BALTIMORE, MD 21208

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BALTIMORE HEBREW

Date

2-21-1996 REISTERSTOWN, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SOL LEVINSON &amp; BROS., INC.

6010 REISTERSTOWN ROAD BALTIMORE, MD 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. LUNG CANCER

Due to (or as a consequence of):

b. EMPHYSEMA

Due to (or as a consequence of):

c. DEHYDRATION

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

6 mos

10 YR

3 DAYS

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ANGINA PECTORIS

DIABETES MELLITUS

ATRIAL FIBRILLATION

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jack E. Missim 4000 Old Court Rd. #203

21208

31. Date filed (Month, Day, Year)

FEB 22 1996

32. Registrar's Signature

John P. ...

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Physician  
/Medical  
Examiner

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

33 00253

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 96 04524

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>Joan G. Bounds</b>				2. Date of Death Month Day Year <b>Feb. 21, 1996</b>				3. Time of Death <b>1:30 A.M.</b>					
4a. Facility Name (If not institution, give street and number) <b>6798 Marriottsville Road #2</b>				4b. City, Town, or Location of Death <b>Marriottsville</b>				4c. County of Death <b>Carroll</b>					
5. Social Security Number		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. <b>64</b>		8. Date of Birth (Month, Day, Year) <b>Jan. 19, 1932</b>		9. Birthplace (State or Foreign Country)					
Usual Residence of Decedent													
10a. State <b>Md.</b>		10b. County <b>Carroll</b>		10c. City, Town or Location <b>Marriottsville</b>				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
10e. Street and Number <b>6798 Marriottsville Rd. #2</b>				10f. Zip Code <b>21104</b>				10g. Citizen of What Country? <b>U.S.A.</b>					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) <b>High School --</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Broker</b>				16b. Kind of Business/Industry <b>Real Estate</b>					
17. Father's Name (First, Middle, Last) <b>George Thomas Phillips</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Margaret Wilhelm</b>							
19a. Informant's Name/Relationship (Type, Print) <b>Charles F. Bounds</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6798 Marriottsville Rd. #2 Marriottsville, Md. 21104</b>									
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Crestlawn Mem. Gardens 2/24/96</b>				20c. Location - City or Town, State <b>Marriottsville, Md.</b>					
21. Signature of Funeral Service Licensee <b>Harry W. Haight</b>				22. Name and Address of Facility <b>Haight Funeral Home P.O. Box 195 Sykesville, Md. 21784</b>									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Cervical Cancer</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last												Approximate interval Between Onset and Death <b>6 years</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
										24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of injury (Month, Day Year)		28b. Time of injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
				28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
29b. Signature and title of certifier <b>Deborah K. Armstrong, M.D.</b>				29c. License number <b>D36986</b>				29d. Date signed (Month, Day, Year) <b>February 21, 1996</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>600 N. Wolfe St. Baltimore, MD 21287 Deborah K Armstrong</b>													
31. Date filed (Month, Day, Year) <b>FFR 2 2 1996</b>				32. Registrar's Signature <b>Andelle</b>									

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Certificate of Death

Reg. No. 96 04525

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARK BROWN		2. Date of Death Month Day Year FEB 17, 1996		3. Time of Death 4:30 PM
	4e. Facility Name (If not institution, give street and number) 4803 KIMBERLEIGH RD		4b. City, Town, or Location of Death BALTO		4c. County of Death N/A
Funeral Director	5. Social Security Number 246-24-6660	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 69 Yrs.	8. Date of Birth (Month, Day, Year) DEC 13, 1926	9. Birthplace (State or Foreign Country) NC
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State MD	10b. County N/A	10c. City, Town or Location BALTO		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number 4803 KIMBERLEIGH		10f. Zip Code 21212		10g. Citizen of What Country? <del>U.D.A.</del> U.S.A.
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1945-47		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: BLACK		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) N/A		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) STEEL WORKER		16b. Kind of Business/Industry STEEL CO		
	17. Father's Name (First, Middle, Last) STUART BROWN		18. Mother's Name (First, Middle, Maiden Surname) FRANCIS DAVIS		
	19a. Informant's Name/Relationship (Type, Print) EARLE BROWN/WIFE		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4803 KIMBERLEIGH RD BALTO, MD 21212		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) GARRISON FOREST VA CEM FEB 21, 96		20c. Location - City or Town, State OWINGS MILLS, MD
	21. Signature of Funeral Service Licensee <i>Patricia B...</i>		22. Name and Address of Facility BETTS FUNERAL HOME 1129 N. CAROLINE ST BALTO, MD 21213		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. Metastatic Small Cell Lung Carcinoma Dua to (or as a consequence of):  b. 1 Dua to (or as a consequence of):  c. Dua to (or as a consequence of):  d.		Approximate Interval Between Onset and Death 6 mo		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Biliary Obstruction by Metastatic Small cell CA Hx Squamous cell (oropharyngeal) CA 1990 Hx Malignant colonic polyps		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Robert L. ...</i>			
29c. License number A 30264		29d. Date signed (Month, Day, Year) 2/20/96			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Robert L. ... 6565 N. ... ST Suite 408 Baltimore MD 21204</i>					
31. Date filed (Month, Day, Year) FEB 22 1996		32. Registrar's Signature <i>Jahia ...</i>			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

252-10 20

252-10 20



ITEMS: 1.6.20b, PER F.H. FILM G-732 2/22/96 t.t

96 04526

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>OSSIE FEATHERSTONE BROOKS</b>		2. DATE OF DEATH MONTH <b>FEB</b> , DAY <b>19</b> , YEAR <b>1996</b>		3. TIME OF DEATH <b>7:30AM</b>
4. SOCIAL SECURITY NUMBER <b>216 207214</b>	5. SEX <b>1</b> <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>85</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>SEPT 1, 1910</b>	8. BIRTHPLACE (State or Foreign Country) <b>VA</b>
9a. FACILITY NAME (If not institution, give street and number) <b>CHURCH NURSING CTR.</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALT. MD.</b>		9c. COUNTY OF DEATH <b>N/A</b>
RESIDENCE OF DECEDENT				
10a. STATE <b>MD</b>	10b. COUNTY <b>N/A</b>	10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
10e. STREET AND NUMBER <b>1227 N. WASHINGTON ST</b>		10f. ZIP CODE <b>21213</b>	10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6th</b> College (1-4 or 5+) <b>N/A</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>FACTORY WORKER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>FACTORY</b>
17. FATHER'S NAME (First, Middle, Last) <b>PELL FEATHERSTONE</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ALLIE BARNETT</b>		
19a. INFORMANT'S NAME (Type/Print) <b>CLEOPATRA HORNE</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1227 N. WASHINGTON ST BALTO, MD 21213</b>		
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>ALLEN'S CHAPEL AME 24 FEB 96</b>		20c. LOCATION — City or Town, State <b>WOODSDALE, NC</b>
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John A. Butts</i>		22. NAME AND ADDRESS OF FACILITY <b>BETTS FUNERAL HOME 1129 N. CAROLINE ST BALTO, MD 21213</b>		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CANCER OF PANCREAS - MONTHS</b> a. DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.				Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Homicide <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY <b>M</b>	28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. SIGNATURE AND TITLE OF CERTIFIER <i>A. P. Nazemi, M.D.</i>		29c. LICENSE NUMBER <b>D17322</b>	29d. DATE SIGNED (Month, Day, Year) <b>FEB. 19, 1996</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>A. P. NAZEMI, M.D. CHURCH HOSPITAL, BALT. MD 21231</b>				
31. DATE FILED (Month, Day, Year) <b>FEB 22 1996</b>		32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>		

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

88 04258

88 04258

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04527

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Lawrence W. Bertel Sr.

2. Date of Death

February 21, 1996 8:30 AM

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

304 North Hammonds Ferry Road

4b. City, Town, or Location of Death

Linthicum Heights Anne Arundel

4c. County of Death

5. Social Security Number

398-12-1086

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

73

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Nov. 15, 1922 Wisconsin

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10a. State

Maryland Anne Arundel

10b. County

10c. City, Town or Location

Linthicum Heights

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

304 North Hammonds Ferry Road

10f. Zip Code

21090

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☒ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☒ Yes ☐ No

If Yes, Give

Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

bricklayer

16b. Kind of Business/Industry

steel

17. Father's Name (First, Middle, Last)

Thomas Bertel

18. Mother's Name (First, Middle, Maiden Surname)

Cecelia Kreuzinger

19a. Informant's Name/Relationship (Type, Print)

Elizabeth Bertel, wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

304 N. Hammonds Ferry Road Linthicum, Md. 21090

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Meadowridge Memorial 2/23/96 Dorsey, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Ambrose Funeral Home of Lansdowne

2719 Hammonds Ferry Road 21227

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

e. PNEUMONIA

Due to (or as a consequence of):

4 days

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. NON-SMALL CELL LUNG CANCER

Due to (or as a consequence of):

8 months

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CORONARY ARTERY DISEASE

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☒ Probably ☐ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☐ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending Investigation☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D18587

29d. Date signed (Month, Day, Year)

FEB 21 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

PAUL GORMLEY 900 CATON AVE BALTO MD 21229

31. Date filed (Month, Day, Year)

FEB 22 1996

32. Registrar's Signature

John Anderson

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 96 04528

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>CHARLES WESLEY BROWN</b>				2. Date of Death Month <b>FEBRUARY</b> Day <b>19</b> Year <b>1996</b>		3. Time of Death <b>3:45 P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>GREATER BALTIMORE MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>TOWSON</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>215-28-0216</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>64</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>July 17, 1931</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
10a. State <b>Md.</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Parkton</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>19624 York Road</b>				10f. Zip Code <b>21120</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates <b>Unknown</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4or 5+) <b>College</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Stationary Engineer</b>			18b. Kind of Business/Industry <b>Research Base Telescope</b>	
17. Father's Name (First, Middle, Last) <b>Charles Julian Brown</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Dorothy Marquard</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Laura L. Brown (Daughter)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2216 Riding Crop Way Baltimore, Maryland 21244</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory</b>		Date <b>Feb. 21, 1996</b>		20c. Location - City or Town, State <b>Catonsville, Maryland</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Leroy M &amp; Russell C Witzke Funeral Homes 1630 Edmondson Avenue Catonsville, Maryland</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. ACUTE CORONARY OCCLUSION</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d.</b>								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, tectory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>P-09383</b>		29d. Date signed (Month, Day, Year) <b>February 19, 1996</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>CHARLES F. O'DONNELL, M.D. 111 HAMLET HILL ROAD BALTIMORE, MD. 21210</b>								
31. Date filed (Month, Day, Year) <b>FEB 22 1996</b>		32. Registrar's Signature 						

SECRET

11

1. The first of the three main points of the report is that the situation in the country is generally stable and that the government is working to improve the economy.

2. The second point is that the government is working to improve the education system and that there is a need for more teachers and schools.

3. The third point is that the government is working to improve the health care system and that there is a need for more hospitals and doctors.

4. The fourth point is that the government is working to improve the infrastructure and that there is a need for more roads and bridges.

5. The fifth point is that the government is working to improve the social services and that there is a need for more housing and social welfare programs.

6. The sixth point is that the government is working to improve the environment and that there is a need for more parks and green spaces.

7. The seventh point is that the government is working to improve the culture and that there is a need for more museums and cultural centers.

8. The eighth point is that the government is working to improve the sports and that there is a need for more stadiums and sports facilities.

9. The ninth point is that the government is working to improve the science and technology and that there is a need for more research and development.

10. The tenth point is that the government is working to improve the overall quality of life and that there is a need for more social and economic development.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 96 04529

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JOYCE A. BYRD

2. Date of Death

Month  
2Day  
16Year  
96

3. Time of Death

8:45 A.M.

4a. Facility Name (If not institution, give street and number)

5422 JONQUIL AVE.

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

CITY

Funeral  
Director

5. Social Security Number

214-62-6955

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

41

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

5/25/1954

9. Birthplace (State or Foreign Country)

BALTIMORE, MD.

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

CITY

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

5422 JONQUIL AVE.

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

☒ Never Married ☐ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

AFR. AMERICAN

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

ACCOUNTANT

16b. Kind of Business/Industry

BLACK &amp; DECKER

17. Father's Name (First, Middle, Last)

LEROY BYRD

18. Mother's Name (First, Middle, Maiden Surname)

ALICE BANNER

19a. Informant's Name/Relationship (Type, Print)

ALICE BANNER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5422 JONQUIL AVE, BALTIMORE, MARYLAND 21215

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

WOODLAWN CEMETERY

Date

2/21/96

20c. Location - City or Town, State

BALTIMORE, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

ESTEP BROTHERS FUNERAL HOME, P.A.

1300 EUTAW PLACE, BALTIMORE, MD. 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Disseminated MAI infection

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

9 mos

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. AIDS

Due to (or as a consequence of):

5 years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

End stage renal disease

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☒ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Andrew R. Mayrer

29c. License number

D 30977

29d. Date signed (Month, Day, Year)

2/19/96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Andrew R. Mayrer, MD, Sinai Hospital, Balto., MD

31. Date filed (Month, Day, Year)

FEB 22 1996

32. Registrar's Signature

John D. Hatcher

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed and filed in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

1950

*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page]*



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04530

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JAMES CALVIN BILLINGS

2. Date of Death

Month FEBRUARY Day 16, Year 1996

3. Time of Death

7:21 P.M.

4a. Facility Name (If not institution, give street and number)

JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

222-16-3591

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

64 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year) June 6, 1931

9. Birthplace (State or Foreign Country)

Delaware

Usual Residence of Decedent

10a. State

Md.

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3112 McElderry Street

10f. Zip Code

21205

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No -

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

7

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

A.J. William Co.

17. Father's Name (First, Middle, Last)

Joshua Billings

18. Mother's Name (First, Middle, Maiden Surname)

Ethel Unknown

19a. Informant's Name/Relationship (Type, Print)

Patricia Billings/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3112 McElderry Street, Balto., Md. 21205

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Woodlawn Cemetery 2/20/96

Date

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Lilly &amp; Zeiler Inc. 1901 Eastern Ave. 21231

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Sudden Death  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Coronary Artery Disease  
Due to (or as a consequence of):c. COPD  
Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypercholesterolemia

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

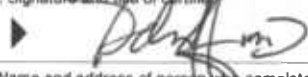
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier



29c. License number

D42908

29d. Date signed (Month, Day, Year)

2/19/96

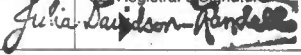
30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

David Scharff, MD 4 S. Highland Ave Baltimore, MD 21224

31. Date filed (Month, Day, Year)

FEB 22 1996

32. Registrar's Signature


State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that this death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 96 04531

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Bessie May Cahill</i>		2. Date of Death Month <i>January</i> Day <i>30</i> Year <i>1996</i>		3. Time of Death <i>4 PM</i>
	4e. Facility Name (If not institution, give street and number) <i>1100 Owens Road</i>		4b. City, Town, or Location of Death <i>Oxon Hill</i>		4c. County of Death <i>Prince George's</i>
Funeral Director	5. Social Security Number <i>unknown</i>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>unknown</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <i>unknown</i>		9. Birthplace (State or Foreign Country) <i>unknown</i>		
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10e. State <i>Maryland</i>	10b. County <i>Prince George's</i>	10c. City, Town or Location <i>Oxon Hill</i>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number <i>1100 Owens Road</i>		10f. Zip Code <i>20745</i>		10g. Citizen of What Country? <i>unknown</i>
	11. Marital Status <i>unknown</i> <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <i>White</i>				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>unknown</i> College (1-4 or 5+) <i>unknown</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>unknown</i>		16b. Kind of Business/Industry <i>unknown</i>
	17. Father's Name (First, Middle, Last) <i>unknown</i>		18. Mother's Name (First, Middle, Maiden Summa) <i>unknown</i>		
	19a. Informant's Name/Relationship (Type, Print) <i>unknown</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>unknown</i>		
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <i>State rem.</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>State rem.</i>		20c. Location - City or Town, State
	21. Signature of Funeral Service Licenses <i>Ronald S. Wade, Dir.</i>		22. Name and Address of Facility <i>State Anatomy Board-655 W. Baltimore Street Rm. B026-Baltimore, Maryland 21201-1559</i>		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <i>Arteriosclerotic cardiovascular disease</i> Due to (or as a consequence of):				Approximate Interval Between Onset and Death
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <i>M</i>
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
State Registrar	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Augusto R. Roony, M.D.</i>		29c. License number <i>A 21230</i>
	29d. Date signed (Month, Day, Year) <i>January 30, 1996</i>		29e. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Augusto R. Roony, M.D., 5009 Rayburn Ct. Cap. Spr. Md 20745</i>		
	31. Date filed (Month, Day, Year) <i>FEB 2 1996</i>		32. Registrar's Signature <i>Juli Anderson-Randall</i>		

102201

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				96 04532			
CERTIFICATE OF DEATH				REG. NO.							
1. DECEDENT'S NAME (First, Middle, Last) <b>GLEND A C. COYLE (GLEND A C. COYLE)</b>				2. DATE OF DEATH MONTH DAY YEAR <b>FEBRUARY 14 1996</b>		3. TIME OF DEATH <b>2:00 P M</b>					
4. SOCIAL SECURITY NUMBER <b>233-34-3004</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>93</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>OCT. 11, 1902</b>		8. BIRTHPLACE (State or Foreign Country) <b>WEST VIRGINIA</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>HOWARD COUNTY GENERAL HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>COLUMBIA</b>		9c. COUNTY OF DEATH <b>HOWARD</b>					
RESIDENCE OF DECEDENT				10a. STATE <b>WV</b>		10b. COUNTY <b>BERKELEY</b>		10c. CITY, TOWN OR LOCATION <b>MARTINSBURG</b>			
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>568 SCRABBLE ROAD</b>		10f. ZIP CODE <b>25401</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b></b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOMEMAKER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>HOME</b>							
17. FATHER'S NAME (First, Middle, Last) <b>JOHN DUNHAM</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>CORA DEHAVEN</b>							
19a. INFORMANT'S NAME (Type/Print) <b>MR. JAMES L. COYLE</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>568 SCRABBLE ROAD, MARTINSBURG, WV 25401</b>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>GERRARDSTOWN PRESBYTERIAN CEMETERY 2/18</b>		DATE <b>2/18</b>		20c. LOCATION — City or Town, State <b>GERRARDSTOWN, WV</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Charles H. Brown</b>				22. NAME AND ADDRESS OF FACILITY <b>BROWN FUNERAL HOME, 327 W. KING STREET PO BOX 821, MARTINSBURG, WV 25401</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>RESPIRATORY FAILURE</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>CONGESTIVE HEART FAILURE</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>DIVERTICULOSIS</b> DUE TO (OR AS A CONSEQUENCE OF): d. <b></b>								Approximate interval between Onset and Death <b>12 hours</b> <b>years</b> <b>3 days</b>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Anemia of chronic disease, atherosclerosis, chronic renal failure, hypertension</b>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) <b>NA</b>		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <b>J. Hunter</b>				29c. LICENSE NUMBER <b>D44782</b>		29d. DATE SIGNED (Month, Day, Year) <b>FEBRUARY 14 1996</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>JERRY ANN HUNTER, MD COLUMBIA MEDICAL PLAN, 2 KNOLL NORTH, MD 21045</b>				31. DATE FILED (Month, Day, Year) <b>FFB 2 2 1996</b>							
32. REGISTRAR'S SIGNATURE											



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				96 04533			
1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH				3. TIME OF DEATH			
Celeste Collins				JANUARY DAY 28 YEAR 1996				3:28 A M			
4. SOCIAL SECURITY NUMBER		5. SEX		6. AGE (In yrs. last birthday)		7. DATE OF BIRTH		8. BIRTHPLACE (State or Foreign Country)			
085-20-4764		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		69 YRS.		April 10, 1926		unknown			
9a. FACILITY NAME (If not institution, give street and number)				9b. CITY, TOWN OR LOCATION OF DEATH				9c. COUNTY OF DEATH			
Union Memorial Hospital				Baltimore City				n/a			
10a. STATE				10b. COUNTY		10c. CITY, TOWN OR LOCATION		10d. INSIDE CITY LIMITS?			
Maryland				n/a		Baltimore		<input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER				10f. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?					
1218 N. Calvert Street				21202		U.S.A.					
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES?		13. WAS DECEDENT OF HISPANIC ORIGIN?		14. RACE — American Indian, Black, White, etc.					
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KING OF BUSINESS/INDUSTRY			
Elementary/Secondary (0-12) College (1-4 or 5 +)				unknown unknown				unknown			
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)							
unknown				unknown							
19a. INFORMANT'S NAME (Type/Print) (son)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)							
Daniel McKenzie				3208 St. Paul Street-Baltimore, Maryland 21218							
20a. METHOD OF DISPOSITION		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		DATE		20c. LOCATION — City or Town, State					
1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify on State rem.)											
21. SIGNATURE OF FUNERAL SERVICE LICENSEE				22. NAME AND ADDRESS OF FACILITY							
Ronald S. Wade, Dir. <i>[Signature]</i>				State Anatomy Board-655 W. Baltimore Street Rm.B026-Baltimore, Maryland 21201-1559							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death			
IMMEDIATE CAUSE (Final disease or condition resulting in death) →								3 DAYS			
a. Sepsis											
DUE TO (OR AS A CONSEQUENCE OF):											
b. Acute Renal Failure								2 WKS.			
DUE TO (OR AS A CONSEQUENCE OF):											
c. Congestive Heart Failure								5 YRS.			
DUE TO (OR AS A CONSEQUENCE OF):											
d.											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											
Depressive Disorder											
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER?				26. PLACE OF DEATH (Check only one)				24a. WAS AN AUTOPSY PERFORMED?			
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
27. MANNER OF DEATH				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK?		28d. DESCRIBE HOW INJURY OCCURED	
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide						M		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one)				29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year)	
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				Sharon C. Jones, M.D.		+176435AJJ068		January 28, 1996			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)				31. DATE FILED (Month, Day, Year)				32. REGISTRAR'S SIGNATURE			
SHARON C. JONES, M.D. Union Memorial Hosp Balt MD 21218				FEB 22 1996				<i>[Signature]</i>			

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04534

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) GLENN				2. Date of Death Month Day Year COATES FEBRUARY 15, 1996				3. Time of Death 5:30AM					
	4a. Facility Name (If not institution, give street and number) 609 NORTH DUKELAND STREET				4b. City, Town, or Location of Death BALTIMORE				4c. County of Death N/A					
Funeral Director	5. Social Security Number 220-64-8016		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 40 Yrs.		8. Date of Birth (Month, Day, Year) July 9, 1955		9. Birthplace (State or Foreign Country) md					
	Usual Residence of Decedent													
To Be Completed by Funeral Director	10a. State md		10b. County N/A		10c. City, Town or Location Balto				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
	10e. Street and Number 2645 Ridgley Street Apt A				10f. Zip Code 21230		10g. Citizen of What Country? U.S.A.							
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black							
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th		College (1-4 or 5+) N/A		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Custodian		16b. Kind of Business/Industry State office Building							
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Ernest Coates Sr.				18. Mother's Name (First, Middle, Maiden Surname) Lorraine Gibson									
	19a. Informant's Name/Relationship (Type, Print) Lorraine Coates - mother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2645 Ridgley St. Apt A Balto, md 21230									
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Sacred Heart of Jesus		20c. Location - City or Town, State Data 4/24/96 Balto, md									
	21. Signature of Funeral Service Licensee William Edmund				22. Name and Address of Facility Marn F.H. West 4300 Wabash Ave									
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Acute Ethanol, Cocaine and Narcotic Intoxication Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.										Approximate Interval Between Onset and Death			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
											24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) Found 2-15-96		28b. Time of Injury Found 5:16 AM		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred unknown					
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner		29b. Signature and title of certifier Dennis J. Chute M.D.								29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) FEBRUARY 15, 1996	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DENNIS J. CHUTE M.D. 111 Penn Street, Baltimore, Maryland 21201													
State Registrar	31. Date filed (Month, Day, Year) FEB 22 1996				32. Registrar's Signature Julia Davidson-Randall									

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

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per F.H. State of Maryland / Department of Health and Mental Hygiene  
Film G732 item 1 2-22-96 rja Certificate of Death

Reg. No. 96 04535

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARY CHOJNOWSKI Mary (nmn)  
Chojnowski

2. Date of Death

February 21, 1996

3. Time of Death

228 AM

4a. Facility Name (If not institution, give street and number)

NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death

GLEN BURNIE

4c. County of Death

ANNE ARUNDEL

Funeral  
Director

5. Social Security Number

215-10-0473

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

11/15/1907

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ANNE ARUNDEL

10c. City, Town or Location

ANNAPOLIS

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

16 FIRST STREET - GREENWOOD ACRES

10f. Zip Code

21401

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
8College (1-4or 5+)  
N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SEAMSTRESS

16b. Kind of Business/Industry

AETNA SHIRT FACTORY

17. Father's Name (First, Middle, Last)

JOHN

RADZISZEWSKI

18. Mother's Name (First, Middle, Maiden Surname)

HELEN

GRABOWSKI

19a. Intendant's Name/Relationship (Type, Print)

EDWARD W. CHOJNOWSKI

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

16 FIRST STREET, ANNAPOLIS, MARYLAND 21401

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

HOLY CROSS CEMETERY

Date

2/24/96

20c. Location - City or Town, State

BROOKLYN PARK, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility SINGLETON FUNERAL HOME

1 SECOND AVENUE S.W., GLEN BURNIE, MD 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ADULT RESPIRATORY DISTRESS SYNDROME

Approximate Interval Between Onset and Death

2 DAYS

Due to (or as a consequence of):

b. CONGESTIVE HEART FAILURE

2 DAYS

Due to (or as a consequence of):

c. AORTIC STENOSIS

5 YEARS

Due to (or as a consequence of):

d. COLON CANCER

5 YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PNEUMONIA, DEMENTIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D28221

29d. Date signed (Month, Day, Year)

February 21, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

DAN H SCHREIBER MD 301 HOSPITAL DRIVE GLEN BURNIE MARYLAND

31. Date filed (Month, Day, Year)

FEB 22 1996

32. Registrar's Signature

Julia [Signature]

21061

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

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REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04536

1. DECEDENT'S NAME (First, Middle, Last) <b>Freida Cohen</b>				2. DATE OF DEATH MONTH DAY YEAR <b>FEB 20, 1996</b>				3. TIME OF DEATH <b>12</b>	
4. SOCIAL SECURITY NUMBER <b>216-07-7856</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>77</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) <b>may 18, 1918</b>	
8. BIRTHPLACE (State or Foreign Country) <b>pennsylvania</b>				9a. FACILITY NAME (If not institution, give street and number) <b>LEVINDALE</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>	
9c. COUNTY OF DEATH <b>N/A</b>				10a. STATE <b>MARYLAND</b>				10b. COUNTY <b>BALTIMORE</b>	
10c. CITY, TOWN OR LOCATION <b>RANDALLSTOWN</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
10e. STREET AND NUMBER <b>9012 MEADOW HEIGHTS RD.</b>				10f. ZIP CODE <b>21133</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>12</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>SALESPERSON</b>		16b. KIND OF BUSINESS/INDUSTRY <b>HOCHILD KOHN</b>					
17. FATHER'S NAME (First, Middle, Last) <b>HARRY KRAMER</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>NETTIE SAVITZ</b>					
19a. INFORMANT'S NAME (Type/Print) <b>MRS. HEDY COHEN (DAUG.)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3513 CHAR-LIL CT. ELLICOTT CITY, MD 21042</b>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>HEBREW YOUNG MEN 2/21/96</b>		DATE <b>2/21/96</b>		20c. LOCATION — City or Town, State <b>BALTIMORE, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Scott M. Gottle</b>				22. NAME AND ADDRESS OF FACILITY <b>SOL LEVINSON &amp; BROS., INC. 6010 REISTERTOWN RD. BALTO., MD 21215</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Metastatic Thyroid CANCER</b> DUE TO (OR AS A CONSEQUENCE OF): a. <b>Metastatic Thyroid CANCER</b> b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate interval Between Onset and Death <b>11/95</b>									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>Debra Swertheimer MD</b>							
		29c. LICENSE NUMBER <b>D23767</b>				29d. DATE SIGNED (Month, Day, Year) <b>February 20, 1996</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DEBRA SWERTHEIMER 2434 W. Belvedere Ave Balto. MD 21215</b>									
31. DATE FILED (Month, Day, Year) <b>FEB 22 1996</b>		32. REGISTRAR'S SIGNATURE <b>Julie Davidson-Randall</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04537

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Hyman Caplan</b>		2. Date of Death Month <b>February</b> Day <b>19</b> Year <b>1996</b>		3. Time of Death <b>2:30 pm</b>
	4a. Facility Name (If not Institution, give street and number) <b>Manor Care Nursing Home</b>		4b. City, Town, or Location of Death <b>Ruxton</b>		4c. County of Death <b>Baltimore</b>
Funeral Director	5. Social Security Number <b>212-12-5776</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>82</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>May 7, 1913</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
Usual Residence of Decedent					
10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Baltimore</b>	
10e. Street and Number <b>6960 Marsue Drive #T2</b>				10f. Zip Code <b>21215</b>	10g. Citizen of What Country? <b>USA</b>
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>College</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Meat Cutter</b>		16b. Kind of Business/Industry <b>Supermarket</b>	
17. Father's Name (First, Middle, Last) <b>Samuel Caplan</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Rose Rosinsky</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Ruth Caplan (wife)</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6960 Marsue Dr. Apt T2 Baltimore Md 21215</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Arlington Cem.</b>		20c. Location - City or Town, State <b>Feb. 20, 1996 Baltimore MD</b>	
21. Signature of Funeral Service Director 			22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215</b>		
23. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Metastatic prostatic Cancer</b> <b>ASCVD</b>					
24. Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. <b>23b. Did tobacco use contribute to the cause of death?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown <b>24a. Was an autopsy performed?</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>24b. Were autopsy findings available prior to completion of cause of death?</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number <b>142736</b>		29d. Date signed (Month, Day, Year) <b>2-20-96</b>	
30. Name and address of person who completed cause of death (Type, Print) <b>DR. AKKAD 7600 OSLER DR., SUITE 203 TOWSON, MD 21204</b>					
31. Date filed (Month, Day, Year) <b>FEB 22 1996</b>		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 96 04538

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Steven J Cross</b>						2. Date of Death Month Day Year <b>February 14 1996</b>		3. Time of Death <b>20:39 PM</b>			
	4a. Facility Name (If not Institution, give street and number) <b>St Agnes Hospital</b>						4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>			
Funeral Director	5. Social Security Number <b>216-62-9260</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>44</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Jan. 14, 1952</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>			
	Usual Residence of Decedent						10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Morrel Park</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						10e. Street and Number <b>1810 Casadel Avenue</b>		10f. Zip Code <b>21230</b>		10g. Citizen of What Country? <b>United States</b>	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>Collega (1-4 or 5+)</b>		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>sales</b>	
	15. Decedent's Education (Specify only highest grade completed)						16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry <b>self-employed</b>			
	17. Father's Name (First, Middle, Last) <b>Paul C. Cross Sr.</b>						18. Mother's Name (First, Middle, Maiden Summa) <b>Lucille Carter</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Paul C. Cross Jr., Brother</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1810 Casadel Avenue Baltimore, Maryland 21230</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Loudon Park Cemetery</b>		20c. Location - City or Town, State <b>2/16 Baltimore, Maryland</b>		21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility <b>Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Road 21227</b>	
	23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediata Causa (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to Immediata causa. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death	
	a. <b>Brain Stem Hemorrhage</b> Due to (or as a consequence of):										4 days	
	b. <b>Cardiac arrhythmia</b> Due to (or as a consequence of):											
	c. Due to (or as a consequence of):											
d. Due to (or as a consequence of):												
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
										24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred		
				28a. Place of Injury - At home, term, street, factory, office building, etc. (Specify)				28t. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated.										29b. Signature and title of certifier <b>Wafer Gamil Third year Resident</b>	29c. License number <b>PO 7535</b>	29d. Date signed (Month, Day, Year) <b>February 14 1996</b>
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) <b>St. Agnes Hospital Wafer S. Gamil</b>												
31. Date filed (Month, Day, Year) <b>FEB 22 1996</b>		32. Registrar's Signature <i>[Signature]</i>										

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 48 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 96 04539

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Frances H. Cerniglia				2. Date of Death Month Day Year Feb 19 96		3. Time of Death 2330 hr	
	4a. Facility Name (If not Institution, give street and number) 1413 N. Rolling Road				4b. City, Town, or Location of Death Catonsville		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 216-07-8058		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 94 Yrs.		8. Date of Birth (Month, Day, Year) March 31, 1901	
					If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
9. Birthplace (State or Foreign Country) Maryland								
Usual Residence of Decedent								
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Catonsville				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
10e. Street and Number 617 Crosby Road				10f. Zip Code 21228		10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bookkeeper			16b. Kind of Business/Industry Produce	
17. Father's Name (First, Middle, Last) Salvatore Palmisano				18. Mother's Name (First, Middle, Maiden Surname) Concetta Pupura				
19a. Informant's Name/Relationship (Type, Print) Frances Shaw (Daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1413 N. Rolling Road Catonsville, Maryland 21228				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) New Cathedral Cemetery Feb. 23, 1996		Date Feb. 23, 1996		20c. Location - City or Town, State Baltimore, Maryland	
21. Signature of Funeral Service Licensee R. C. Witzke Jr.				22. Name and Address of Facility Leroy M & Russell C Witzke Funeral Homes 1630 Edmondson Avenue Catonsville, Maryland				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. Nephrosclerotic renal failure Due to (or as a consequence of): b. Arteriosclerosis Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accidental 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Laurena R. Gallagher MD				29c. License number D 01786		29d. Date signed (Month, Day, Year) Feb. 20, 96		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) L. GALLAGHER, MD 3455 WILKENS AVE, BALTO MD 21229								
31. Date filed (Month, Day, Year) FEB 22 1996								

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04540

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Larry M Carter</i>				2. Date of Death Month <i>02</i> Day <i>17</i> Year <i>96</i>		3. Time of Death <i>15:28</i>	
	4a. Facility Name (If not institution, give street and number) <i>University of Maryland Hospital</i>				4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death <i>Baltimore City</i>	
Funeral Director	5. Social Security Number <i>212-70-5968</i>		8. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>38</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>10 24 57</i>	9. Birthplace (State or Foreign Country) <i>BALTO. MARYLAND</i>
	Usual Residence of Decedent							
10a. State <i>MARYLAND</i>		10b. County <i>BALTIMORE CITY</i>		10c. City, Town or Location <i>BALTIMORE</i>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <i>3026 PRESSTMAN STREET</i>				10f. Zip Code <i>21216</i>		10g. Citizen of What Country? <i>U.S.A.</i>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>BLACK</i>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4or 5+) <i>0</i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>SELF EMPLOYED</i>		16b. Kind of Business/Industry <i>BUS DRIVER</i>		
17. Father's Name (First, Middle, Last) <i>NEIL CARTER</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>ROSA CARTER</i>				
19a. Informant's Name/Relationship (Type, Print) <i>ALVA CARTER (WIFE)</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3026 PRESSTMAN STREET BALTIMORE, MARYLAND 21216</i>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <i>WOODLAWN CEMETERY</i>		20c. Location - City or Town, State <i>2/22/96 WOODLAWN, MARYLAND</i>		
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <i>ESTEP BROTHERS FUNERAL HOME PA. 1300 EUTAW PLACE BALTIMORE, MARYLAND 21217</i>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <i>Respiratory Failure</i> Due to (or as a consequence of): b. <i>Electrolyte Abnormalities</i> Due to (or as a consequence of): c. <i>End Stage Liver Disease</i> Due to (or as a consequence of): d. <i>Alcoholic Cirrhosis</i>								Approximate Interval Between Onset and Death <i>2 days</i>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29c. License number <i>P09736</i>		29d. Date signed (Month, Day, Year) <i>02/17/96</i>		
29b. Signature and title of certifier <i>I. Michael Guonewardene MD</i>				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>I. Michael Guonewardene Dept of Medicine University of Maryland Hospital, Baltimore, MD</i>				
31. Date filed (Month, Day, Year) <i>FEB 22 1996</i>				32. Registrar's Signature <i>[Signature]</i>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To Hospital or Attending Physician: The law requires that the death certificate be executed within 48 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

0417: 147 7 3



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04541

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>DOROTHY DAVIS</b>				2. Date of Death Month <b>2</b> Day <b>13</b> Year <b>96</b>				3. Time of Death <b>7:28 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>University of Maryland</b>				4b. City, Town, or Location of Death <b>Baltimore</b>				4c. County of Death <b>n/a</b>	
Funeral Director	5. Social Security Number <b>212-48-2176</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>47</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Feb. 23, 1948</b>		9. Birthplace (State or Foreign Country) <b>unknown</b>	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>n/a</b>		10c. City, Town or Location <b>Baltimore</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <b>1821 E. Eager Street</b>				10f. Zip Code <b>21205</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
	11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>unknown</b> College (1-4 or 5+) <b>unknown</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>unknown</b>			16b. Kind of Business/Industry <b>unknown</b>		
	17. Father's Name (First, Middle, Last) <b>unknown</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>unknown</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Renee Davis (daughter)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1821 E. Eager Street-Baltimore, Maryland 21205</b>					
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>An State rem.</b>				20b. Place of Disposition (Name of cemetery, crematory or other place)		Date		20c. Location - City or Town, State	
	21. Signature of Funeral Service Licensee <b>Ronald S. Wade Dir.</b>				22. Name and Address of Facility <b>State Anatomy Board-655 W. Baltimore Street Rm.B026-Baltimore, Maryland 21201-1559</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>Immediate Cause (Final disease or condition resulting in death) <b>SEPSIS</b></p> <p>Due to (or as a consequence of): <b>NECROTISING FASCIITIS</b></p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> </div> <div style="width: 15%;"> <p>Approximate Interval Between Onset and Death <b>4 DAYS</b></p> <p><b>10 DAYS</b></p> </div> </div>									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide										
28a. Date of Injury (Month, Day, Year)										
28b. Time of Injury <b>M</b>										
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
28d. Describe how injury occurred										
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)										
28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier <b>B. Nelson M.D.</b>										
29c. License number <b>D45106</b>										
29d. Date signed (Month, Day, Year) <b>2/13/96</b>										
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>B. NELSON 22 S. GREENE ST, BALTIMORE, MD</b>										
31. Date filed (Month, Day, Year) <b>FEB 22 1996</b>										
Registrar's Signature <b>J. Davidson</b>										

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

1954





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04542

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JOSIE DENNIS</b>				2. Date of Death Month <b>Feb</b> Day <b>17</b> Year <b>1996</b>		3. Time of Death <b>5:30 A.M.</b>	
	4a. Facility Name (If not Institution, give street and number) <b>4826 Cordelia Ave</b>				4b. City, Town, or Location of Death <b>Balto</b>		4c. County of Death <b>NIA</b>	
Funeral Director	5. Social Security Number <b>248-30-6724</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>81</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>March 24, 1914</b>	9. Birthplace (State or Foreign Country) <b>S.C.</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>md</b>		10b. County <b>NIA</b>		10c. City, Town or Location <b>Balto</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <b>4826 Cordelia Ave</b>				10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>U.S.A</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>3rd</b> College (13 or 5+) <b>NIA</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Cook</b>		16b. Kind of Business/Industry <b>Public Schools</b>			
	17. Father's Name (First, Middle, Last) <b>Leonard Outen</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Sarah Moore</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Lester Dennis - son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4826 Cordelia Ave Balto, md 21215</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory, or other place) <b>Lincoln Memorial Cem</b>		Date <b>2/24/96</b>		20c. Location - City or Town, State <b>Columbia, S.C.</b>	
	21. Signature of Funeral Service Licensee <b>Chabriele Cook</b>				22. Name and Address of Facility <b>March F.H. West 4300 Wabash Ave</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
	Approximate Interval Between Onset and Death							
Immediate Cause (Final disease or condition resulting in death) a. <b>CANCER of esophagus</b> Due to (or as a consequence of): b. <b>Malnutrition</b> Due to (or as a consequence of): c. <b>Dehydration</b> Due to (or as a consequence of): d. <b>Hypertension</b>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
		28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>A. W. M.</b>		29c. License number <b>30339</b>		29d. Date signed (Month, Day, Year) <b>02/19/96</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MILAN WISTER, MD; 19 WALKER AVE; BALTIMORE, MD 21204</b>								
31. Date filed (Month, Day, Year) <b>FEB 22 1996</b>		32. Registrar's Signature <b>Julia Davidson-Randall</b>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

ITEM: 23 PART I, PER DR. FILM 6-733 State of Maryland / Department of Health and Mental Hygiene

3/29/96 t.t

Certificate of Death

Reg. No. 96 04543

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

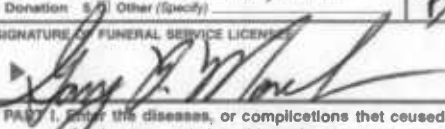

1. Decedent's Name (First, Middle, Last) <b>Silas Abraham Dooley</b>						2. Date of Death Month Day Year <b>Feb. 21, 1996</b>			3. Time of Death <b>1:35 A.M.</b>		
4a. Facility Name (If not institution, give street and number) <b>Severna Park Meridian Nursing Home</b>						4b. City, Town, or Location of Death <b>Severna Park</b>			4c. County of Death <b>Anne Arundel</b>		
5. Social Security Number <b>224-24-1581</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>72</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) <b>Jan. 18, 1924</b>	
9. Birthplace (State or Foreign Country) <b>Virginia</b>											
10a. State <b>Maryland</b>			10b. County <b>Anne Arundel</b>			10c. City, Town or Location <b>Gambrills</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>1515 Defense Hwy.</b>						10f. Zip Code <b>21054</b>			10g. Citizen of What Country? <b>United States</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+)						16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Assembly Line Worker</b>			16b. Kind of Business/Industry <b>Manufacturing</b>		
17. Father's Name (First, Middle, Last) <b>Charles Edgart Dooley</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Elizabeth Rush</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Marie Cichocki/Daughter</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>96 Mary Lane Apt. 303 Glen Burnie, MD 21061</b>					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory Feb. 24, 1996</b>		Date <b>Feb. 24, 1996</b>		20c. Location - City or Town, State <b>Catonsville, MD</b>			
21. Signature of Funeral Service Licensee <b>Cori L. Ebaugh</b>						22. Name and Address of Facility <b>Kirkley-Ruddick Funeral Home 421 Crain Hwy. S.E. Glen Burnie, MD 21061</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>LUNG METASTATIC COLON CARCINOMA</b>										Approximate Interval Between Onset and Death <b>2 YRS.</b>	
Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
										24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
										24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier <b>Attender</b>			29c. License number <b>D 21726</b>			29d. Date signed (Month, Day, Year) <b>2/22/96</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Dr. Surya Mundra 1600 Crain Hwy. Suite 106 Glen Burnie, MD 21061</b>											
31. Date filed (Month, Day, Year) <b>FEB 22 1996</b>											

State Registrar



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>LAURETTA DUKES</b>				2. DATE OF DEATH MONTH DAY YEAR <b>02 18 96</b>		3. TIME OF DEATH <b>15:45 M</b>	
4. SOCIAL SECURITY NUMBER <b>220-36-3917</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>55</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>02-19-1940</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>University of Maryland Medical System</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH <b>N/A</b>	
10a. STATE <b>MD</b>		10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>3304 CLIFTON AVE.</b>				10f. ZIP CODE <b>21216</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10TH</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOUSEWIFE</b>		16b. KIND OF BUSINESS/INDUSTRY <b>HOME</b>			
17. FATHER'S NAME (First, Middle, Last) <b>ROGER NORRIS</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>VIRGINIA SMITH</b>			
19a. INFORMANT'S NAME (Type/Print) <b>JANICE CROSTY</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2401 PRES BURY ST. BALT. MD. 21216</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of place, cemetery or other place) <b>BALTIMORE NATIONAL 2/22/96 BALTIMORE MD</b>		20c. LOCATION — City or Town, State <b>BALTIMORE MD</b>		20d. DATE <b>2/22/96</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FUNERAL HOME <b>GARY T. MARCH FUNERAL HOME, INC. 270 FRED HILTON PASS BALT. MD. 21219</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Intracerebral hemorrhage</b>  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF):  b. DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Ritha Chea MD</b>				29c. LICENSE NUMBER <b>P09729</b>		29d. DATE SIGNED (Month, Day, Year) <b>02-18-96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>RITHA CHEA M.D. 22 S. GREENE ST. BALTIMORE, MD 21201</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 22 1996</b>		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00 01244

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04545

1. DECEDENT'S NAME (First, Middle, Last) Ruth Comstock Dunlap				2. DATE OF DEATH MONTH DAY YEAR Feb. 20, 1996				3. TIME OF DEATH 12:24 p.m.					
4. SOCIAL SECURITY # 424424-5043X <del>484-09-1910</del>				5. AGE (In yrs. last birthday) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Jan. 13, 1919		8. BIRTHPLACE (State or Foreign Country) New York	
9a. FACILITY NAME (If not institution, give street and number) 5425 Luckpenny Place						9b. CITY, TOWN OR LOCATION OF DEATH Columbia				9c. COUNTY OF DEATH Howard			
RESIDENCE OF DECEDENT													
10a. STATE Maryland				10b. COUNTY Howard				10c. CITY, TOWN OR LOCATION Columbia				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 5425 Luckpenny Place						10f. ZIP CODE 21045				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Virologist				16b. KIND OF BUSINESS/INDUSTRY Medical Research					
17. FATHER'S NAME (First, Middle, Last) George Frederick Comstock						18. MOTHER'S NAME (First, Middle, Maiden Surname) Ella Wills							
19a. INFORMANT'S NAME (Type/Print) Elizabeth Paige Dunlap						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5425 Luckpenny Place Columbia, MD 21045							
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory, Inc. 02/21/96				20c. LOCATION — City or Town, State Baltimore, MD					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dawn F. McDonald						22. NAME AND ADDRESS OF FACILITY Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. metastatic breast carcinoma to lung DUE TO (OR AS A CONSEQUENCE OF):													
b. Breast carcinoma (adenocarcinoma) DUE TO (OR AS A CONSEQUENCE OF):													
c. DUE TO (OR AS A CONSEQUENCE OF):													
d. DUE TO (OR AS A CONSEQUENCE OF):													
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. chronic obstructive pulmonary disease													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) N/A		28b. TIME OF INJURY N/A M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED N/A			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) N/A						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) N/A							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER Allen Funk MD						29c. LICENSE NUMBER D43219				29d. DATE SIGNED (Month, Day, Year) Feb. 21, 1996			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Allen Funk MD 2 Knoll N Dr, Columbia MD 21045													
31. DATE FILED (Month, Day, Year) FEB 22 1996				32. REGISTRAR'S SIGNATURE John H. ...									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2072 2



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 96 04546

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Nancy Eutsler				2. Date of Death Month Day Year Feb. 21 1996		3. Time of Death 11:55 AM		
	4a. Facility Name (If not institution, give street and number) 2645 Purnell Drive				4b. City, Town, or Location of Death Baltimore		4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 190-20-6547		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 68 Yrs.		8. Date of Birth (Month, Day, Year) Jan. 14, 1928		
	9. Birthplace (State or Foreign Country) Pennsylvania		10a. State S.C.		10b. County Georgetown		10c. City, Town or Location Pawley's Island		
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 1 Sailfish Drive		10f. Zip Code 29585		10g. Citizen of What Country? U.S.A.	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 1		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home					
17. Father's Name (First, Middle, Last) Albert Zenner				18. Mother's Name (First, Middle, Maiden Surname) Marie Higgins					
19a. Informant's Name/Relationship (Type, Print) Karin A. Dennis (Daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2645 Purnell Drive Baltimore, Maryland 21207					
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory		20c. Location - City or Town, State Catonsville, Maryland		20d. Date Feb. 22, 1996			
21. Signature of Funeral Service Licensee R. C. Witke Jr.				22. Name and Address of Facility Leroy M & Russell C Witzke Funeral Homes 1630 Edmondson Avenue Catonsville, Maryland					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Squamous cell carcinoma of lung Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 7 months	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		28. Place of Death (Check only one) Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Marshall A. Levine		29c. License number D17873		29d. Date signed (Month, Day, Year) 2/21/96			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marshall A. Levine 4000 Old Court Rd. Baltimore, MD 21208									
31. Date filed (Month, Day, Year) FEB 22 1996		32. Registrar's Signature Julia Davidson-Randall							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04547

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

GEORGE W. FRAZIER

2. Date of Death

February 18, 1996

3. Time of Death

5:00 A.M.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

3915 Cedardale Road

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

NA

5. Social Security Number

214-05-3692

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan 11, 1912

9. Birthplace (State or Foreign Country)

S.C.

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3915 Cedardale Road

10f. Zip Code

21215

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10th grade

College (14 or 5+)

NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Fork Lift Operator

16b. Kind of Business/Industry

General Refactory

17. Father's Name (First, Middle, Last)

John Frazier

18. Mother's Name (First, Middle, Maiden Surname)

Julia Terry

19a. Informant's Name/Relationship (Type, Print)

Joseph Frazier Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

609 Archer Street Balto, MD 21230

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Woodson Park

Date

2/22/96

20c. Location - City or Town, State

Balto, MD

21. Signature of Funeral Service Licensee

Gabrielle Cook

22. Name and Address of Facility

Marchmont H. West  
4300 Wabash Avenue Balto, MD 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Due to (or as a consequence of):

Prostate Cancer

Approximate Interval Between Onset and Death

2 years

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive heart failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M. Delaney MD

29c. License number

D-40521

29d. Date signed (Month, Day, Year)

February 21, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. OCHANEY

3350 Wilkens Avenue

Suite 306  
Baltimore, MD 21229

31. Date filed (Month, Day, Year)

FEB 22 1996

32. Registrar's Signature

Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.  
State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

Reg. No. 96 04548

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

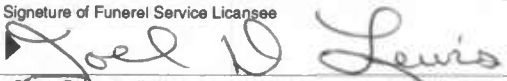


To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

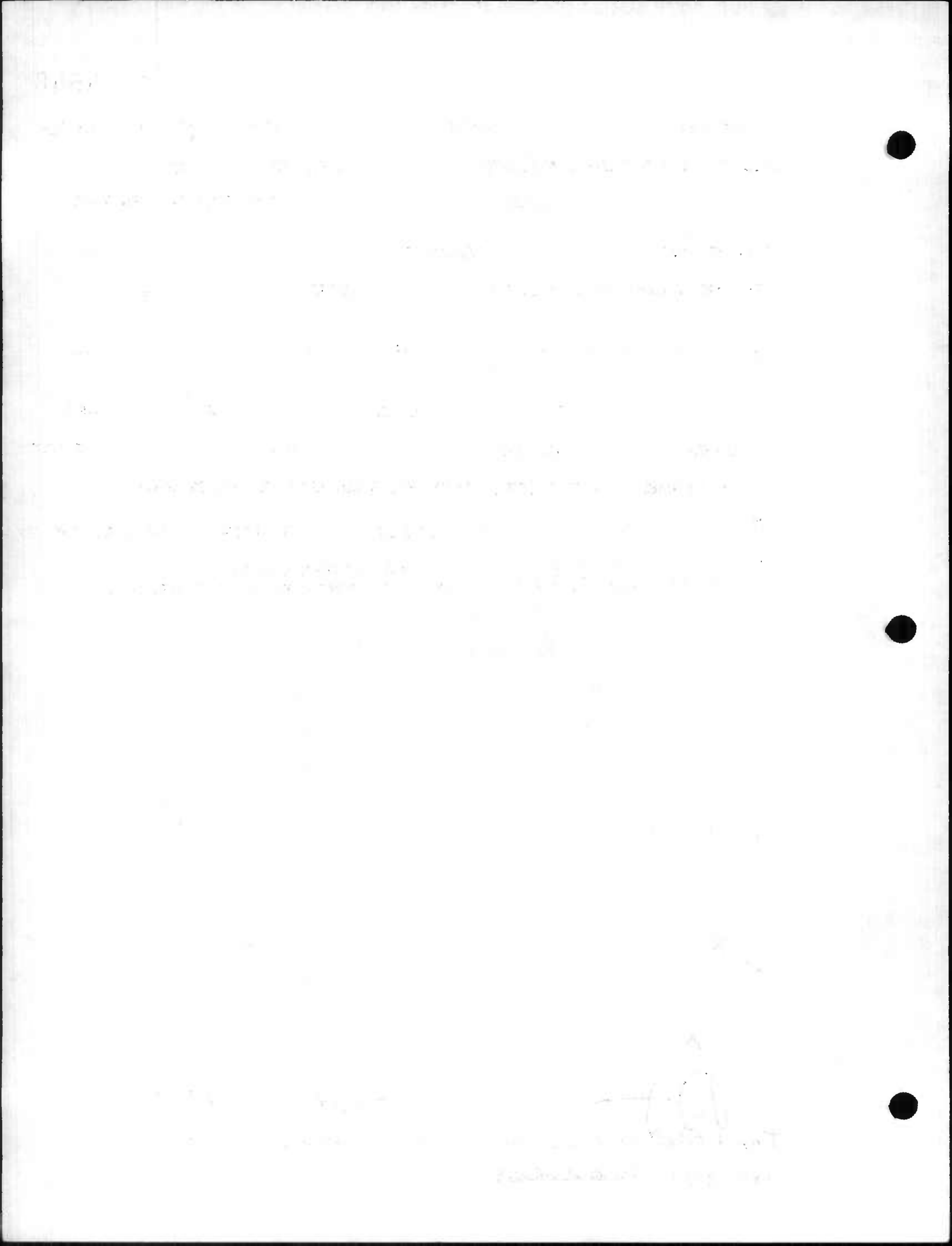
Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>THERESA FREILICH</b>		2. Date of Death Month Day Year <b>FEBRUARY 11, 1996</b>		3. Time of Death <b>4:30pm</b>	
4a. Facility Name (If not institution, give street and number) <b>5715 PARK HEIGHTS AVE., APT. 508</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>	
5. Social Security Number <b>161-20-2584</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>85</b> Yrs.	
8. Date of Birth (Month, Day, Year) <b>AUG. 27, 1910</b>		9. Birthplace (State or Foreign Country) <b>NEW YORK</b>			
10a. State <b>MARYLAND</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>5715 PARK HEIGHTS AVE., APT. 508</b>		10f. Zip Code <b>21215</b>	
10g. Citizen of What Country? <b>USA</b>		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>2</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>OWNER</b>		16b. Kind of Business/Industry <b>DRESS MANUFACTURER</b>	
17. Father's Name (First, Middle, Last) <b>NATHAN GINSBURG</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>GUSSIE GLADSTONE</b>			
19a. Informant's Name/Relationship (Type, Print) <b>MR. MICHAEL FREILICH (SON)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>13004 FALLS RD. HUNT VALLEY, MD 21030</b>			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>NEW MONTEFIORE</b>		20c. Location - City or Town, State <b>2-13-1996-PINELAWN, L.I., NEW YORK</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Cardiovascular event</b> Due to (or as a consequence of): <b>b. Atherosclerotic disease</b> Due to (or as a consequence of): <b>c. hypertension</b> Due to (or as a consequence of): <b>d.</b> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and Title of Certifier 	
29c. License number <b>D19414</b>		29d. Date signed (Month, Day, Year) <b>2/12/96</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Ina T. Fine 2324 W. Joppa Rd LUTHERVILLE, MD 21093</b>	
31. Date filed (Month, Day, Year) <b>FEB 22 1996</b>		32. Registrar's Signature 			



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

96 04549

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Bertha Cecelia Fehsenfeld</b>				2. DATE OF DEATH MONTH DAY YEAR <b>Feb. 19, 1996</b>		3. TIME OF DEATH <b>6:45 a m</b>	
4. SOCIAL SECURITY NUMBER <b>214-38-4247</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>90</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Feb. 22, 1905</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>410 Hawthorne Road</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Linthicum</b>	
9c. COUNTY OF DEATH <b>Anne Arundel</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Anne Arundel</b>	
10c. CITY, TOWN OR LOCATION <b>Linthicum</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>410 Hawthorne Road</b>	
10f. ZIP CODE <b>21090</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+) <b>Management</b>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Management</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Hotel Industry</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Edmund Earl Evans</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Cecelia Peters</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Richard Earl Fehsenfeld</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>410 Hawthorne Road Linthicum, MD 21090</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metro Crematory, Inc. 02/22/96</b>			
20c. LOCATION — City or Town, State <b>Baltimore, MD</b>				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Dawn F. McDonald</b> <b>Dawn F. McDonald</b>			
22. NAME AND ADDRESS OF FACILITY <b>Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228</b>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Gangrene, lower extremities</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Peripheral Artery Disease</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Hypertension</b> DUE TO (OR AS A CONSEQUENCE OF):  Approximate Interval Between Onset and Death <b>6 weeks</b> <b>10 years</b> <b>20 years</b>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic Bronchitis</b>				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) <b>Feb. 19, 1996</b>			
28b. TIME OF INJURY <b>M</b>				28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>William M. Russell MD</b>				29c. LICENSE NUMBER <b>D30182</b>			
29d. DATE SIGNED (Month, Day, Year) <b>Feb. 19, 1996</b>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>William M. Russell MD 3320 BENSON AVE BALT. MD 21227</b>			
31. DATE FILED (Month, Day, Year) <b>FEB 22 1996</b>				32. REGISTRAR'S SIGNATURE <b>John A. Hunsicker</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

68760

10

DIVISION OF VITAL RECORDS, P.O. BOX 68760  
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 96 04550

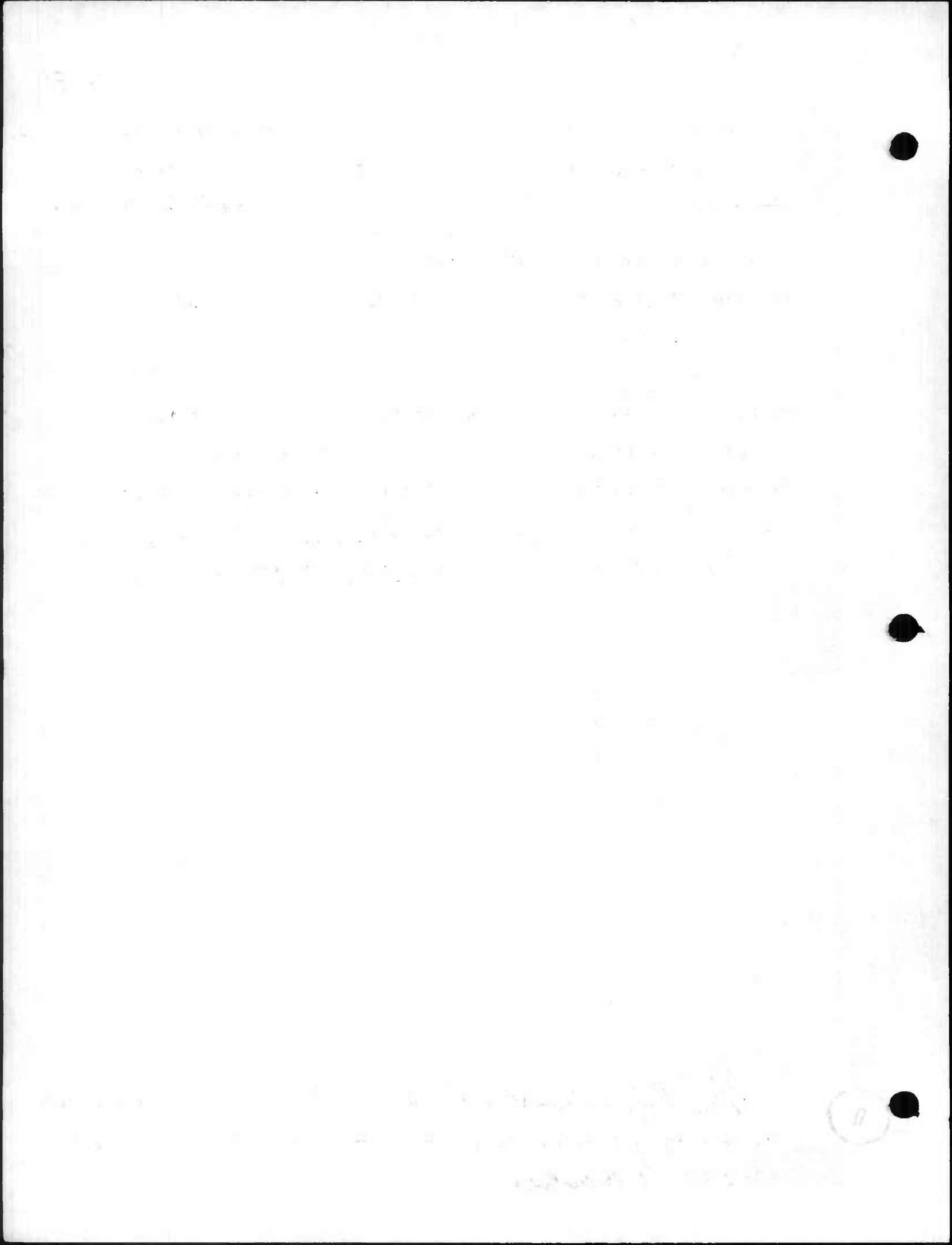
Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Elmer C. Fitzwater</b>				2. Date of Death Month Day Year <b>February 21, 1996</b>		3. Time of Death <b>2:15a.m.</b>	
	4a. Facility Name (If not institution, give street and number) <b>St. Agnes Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>217-01-0512</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>84</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>September 28, 1911</b>	9. Birthplace (State or Foreign Country) <b>Virginia</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Catonsville</b>		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number <b>906 Southridge Road</b>				10f. Zip Code <b>21228</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>0-9th</b> College (1-4or 5+) <b>-----</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>machinist</b>		16b. Kind of Business/Industry <b>electric</b>		
17. Father's Name (First, Middle, Last) <b>George M. Fitzwater</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Ida Dora Shoemaker</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Imogene C. Fitzwater</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>906 Sothridge Road Catonsville, Md. 21228</b>				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Meadowrdridge Cemetery</b>		20c. Location - City or Town, State <b>Dorsey, Maryland</b>		
21. Signature of Funeral Service Licensee				22. Name and Address of Facility <b>Ambrose Funeral Home, Inc. 1328 Sulphur Spring Road 21227</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e. <b>Terminal Pulmonary Infection</b> Due to (or as a consequence of): <b>6 days</b>								
b. <b>Cardiovascular Accident</b> Due to (or as a consequence of): <b>9 days</b>								
c. <b>Extensive Cerebral Vascular Thrombosis of</b> Due to (or as a consequence of): <b>9 days</b>								
d. <b>Right Cerebrum</b>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
<b>Diabetes Melitus 1</b>								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <b>Herbert J. Levickas M.D.</b>				29c. License number <b>D15958</b>		29d. Date signed (Month, Day, Year) <b>February 21, 1996</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Dr. Herbert J. Levickas, M.D. 5404 East Drive Baltimore, Md. 21227</b>								
31. Date filed (Month, Day, Year) <b>FEB 22 1996</b>				32. Registrar's Signature <b>Juli [Signature]</b>				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 96 04551

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>IRETHA Gaither</b>						2. Date of Death Month <b>February</b> Day <b>18th</b> Year <b>1996</b>		3. Time of Death <b>8:30pm</b>		
	4a. Facility Name (If not institution, give street and number) <b>Liberty medical Center</b>						4b. City, Town, or Location of Death <b>Balto</b>		4c. County of Death <b>NTA</b>		
Funeral Director	5. Social Security Number <b>239-18-1415</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>75</b> Yrs.		8. Date of Birth Month, Day, Year <b>Feb 11, 1921</b>		9. Birthplace (State or Foreign Country) <b>N.C.</b>		
	Usual Residence of Decedent										
10a. State <b>md</b>		10b. County <b>NTA</b>		10c. City, Town or Location <b>Balto</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number <b>3619 Reisterstown Rd</b>				10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>U.S.A.</b>					
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8th</b> College (1-4 or 5+) <b>NTA</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Domestic</b>			16b. Kind of Business/Industry <b>Homes</b>				
17. Father's Name (First, Middle, Last) <b>Daniel Tatum</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Viola Howell</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Husband</b> <b>Edward Gaither</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3619 Reisterstown Rd. Balto, md 21215</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Woodlawn Cemetery</b>			20c. Location - City or Town, State <b>2/23/96 Woodlawn, md</b>					
21. Signature of Funeral Service Licensee <b>Gabriele Cook</b>						22. Name and Address of Facility <b>March F. H. - west 4300 Wabash Ave</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. ANOXIC encephalopathy</b> Due to (or as a consequence of): <b>b. PNEUMONIA</b> Due to (or as a consequence of): <b>c. PNEUMOTHORAX</b> Due to (or as a consequence of): <b>d. PANCREATITIS</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accidental <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
			28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier <b>Terance L. Lamb</b>						29c. License number <b>D37003</b>		29d. Date signed (Month, Day, Year) <b>February 18th 1996</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Terance L. LAMB Liberty medical Ctr, Baltimore, md 21215</b>											
31. Date filed (Month, Day, Year) <b>FEB 22 1996</b>			32. Registrar's Signature <b>Julia Davidson-Randall</b>								

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 96 04552

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Gerald Green</u>				2. Date of Death Month <u>02</u> Day <u>17</u> Year <u>96</u>		3. Time of Death <u>12:34 Am</u>	
	4a. Facility Name (If not Institution, give street and number) <u>Baltimore VA medical Center</u>				4b. City, Town, or Location of Death <u>Baltimore</u>		4c. County of Death <u>Baltimore</u>	
Funeral Director	5. Social Security Number <u>216 16 5986</u>		6. Sex <u>1</u> M <u>2</u> F	7. Age (In yrs. last birthday) <u>71</u> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <u>04 28 24</u>	9. Birthplace (State or Foreign Country) <u>md</u>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <u>md</u>		10b. County <u>Balto</u>		10c. City, Town or Location <u>Randallstown</u>		10d. Inside City Limits <u>1</u> Yes <u>2</u> No	
	10e. Street and Number <u>3727 Springdell Rd</u>				10f. Zip Code <u>21133</u>		10g. Citizen of What Country? <u>U.S.A.</u>	
	11. Marital Status <u>1</u> Navar Married <u>2</u> Married <u>3</u> Widowed <u>4</u> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <u>1</u> Yes <u>2</u> No If Yes, Give Year or Dates: <u>7/13/43 1/31/46</u>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <u>1</u> Yes <u>2</u> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>Black</u>	
	15. Decedent's Education (Specify only highest grade completed) <u>8th</u> Elementary/Secondary (0-12) <u>N/A</u> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Baker's Helper</u>		16b. Kind of Business/Industry <u>Bakery</u>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <u>Lawrence Green</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Margaret Toogood</u>			
	19a. Informant's Name/Relationship (Type, Print) <u>Mabel Green - wife</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>1520 W. North Ave Balto, md 21217</u>			
	20a. Method of Disposition <u>1</u> Burial <u>2</u> Cremation <u>3</u> Removal from State <u>4</u> Donation <u>5</u> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Garrison Forest Vet</u>		Data <u>2/22/96</u>	20c. Location - City or Town, State <u>Owing Mills, md</u>		
	21. Signature of Funeral Service Licensee <u>William Edmond</u>		22. Name and Address of Facility <u>March F.H. West 4300 Wabash Ave</u>					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <u>Renal Failure</u> Due to (or as a consequence of): b. <u>Respiratory Failure</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <u>1</u> Yes <u>2</u> No <u>3</u> Probably <u>4</u> Unknown
	24a. Was an autopsy performed? <u>1</u> Yes <u>2</u> No							24b. Were autopsy findings available prior to completion of cause of death? <u>1</u> Yes <u>2</u> No
	25. Was case referred to medical examiner? <u>1</u> Yes <u>2</u> No		28. Place of Death (Check only one) Hospital: <u>1</u> Inpatient <u>2</u> ER/Outpatient <u>3</u> DOA Other: <u>4</u> Nursing Home <u>5</u> Residence <u>6</u> Other (Specify)					
27. Manner of Death <u>1</u> Natural <u>5</u> Pending Investigation <u>2</u> Accident <u>6</u> Could not be determined <u>3</u> Suicide <u>4</u> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? <u>1</u> Yes <u>2</u> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <u>1</u> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <u>2</u> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <u>William C Davis MD</u>		29c. License number <u>MR0824</u>		29d. Date signed (Month, Day, Year) <u>2/17/96</u>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>William C Davis MD Baltimore VAMC Balto MD 21201</u>								
31. Date filed (Month, Day, Year) <u>FEB 22 1996</u>		32. Registrar's Signature <u>Julia Davidson</u>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar

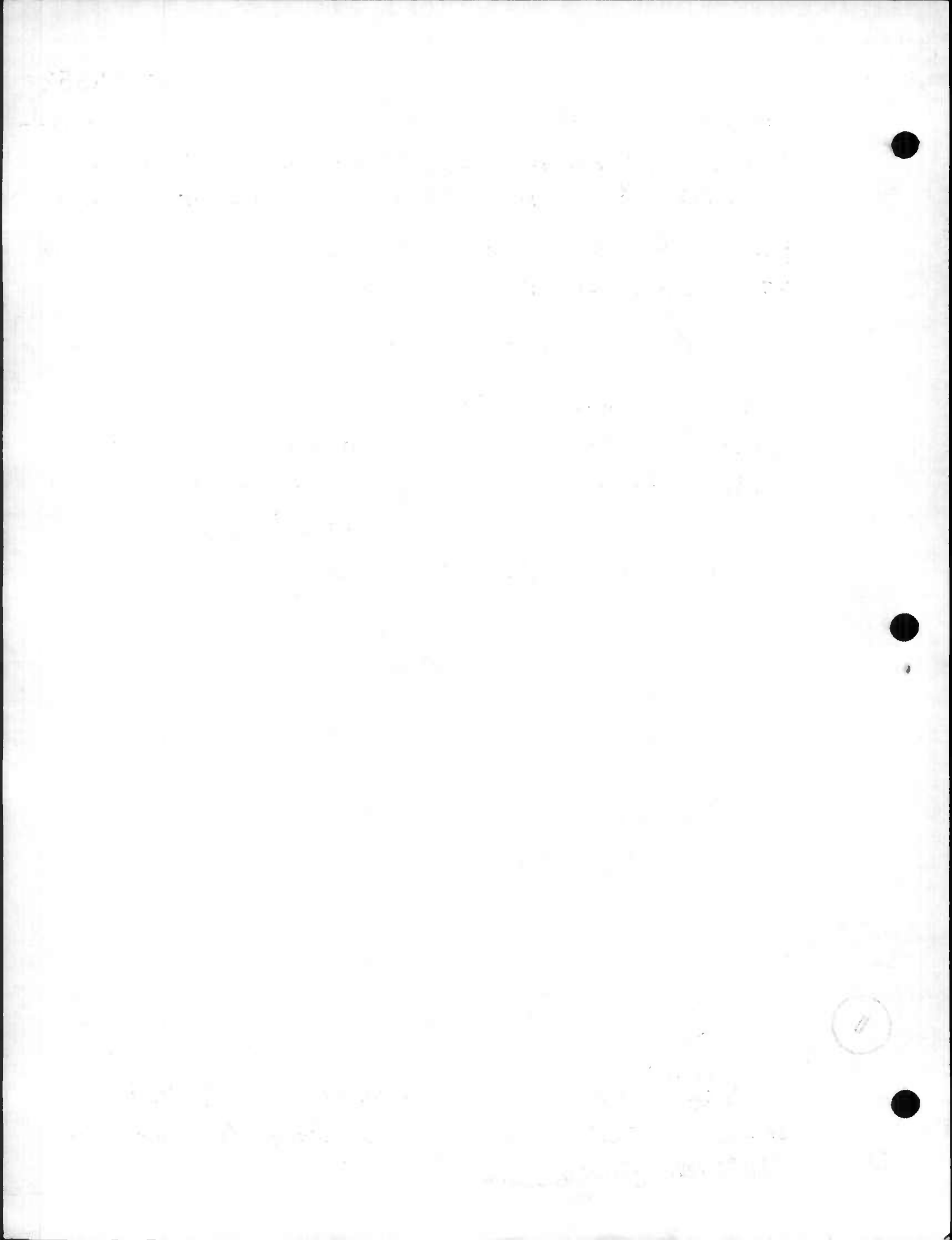
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 48 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

4+1



State of Maryland / Department of Health and Mental Hygiene

part II 2-22-96 per dr rja

## Certificate of Death

Reg. No.

96 04553

**Division of Vital Records, P.O. Box 68760,**





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04554

1. DECEDENT'S NAME (First, Middle, Last) <b>WILLIAM GEIGER, Jr.</b>				2. DATE OF DEATH MONTH DAY YEAR <b>Feb. 20, 1996</b>		3. TIME OF DEATH <b>3:00 P. M.</b>					
4. SOCIAL SECURITY NUMBER <b>217-01-8564</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>80</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>November 16, 1915</b>		8. BIRTHPLACE (State or Foreign Country) <b>New Jersey</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>3313 Glenmore Avenue</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>			9c. COUNTY OF DEATH <b>-NA-</b>				
RESIDENCE OF DECEDENT				10a. STATE <b>Maryland</b>		10b. COUNTY <b>-NA-</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>			
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>3313 Glenmore Avenue</b>		10f. ZIP CODE <b>21214</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>W.W.II</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b></b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Clerical</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Railroad</b>					
17. FATHER'S NAME (First, Middle, Last) <b>William Geiger, Sr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Cora Stehlin</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Mary Geiger</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3313 Glenmore Avenue Baltimore, Maryland 21214</b>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place) <b>Moreland Memorial Park February 23, 1996</b>		20c. LOCATION — City or Town, State <b>Baltimore, Maryland</b>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Mark T. Zavovna</b>		22. NAME AND ADDRESS OF FACILITY <b>Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, MD 21214</b>									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one condition on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Glioblastoma, aggressive</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> A <input type="checkbox"/> P <input type="checkbox"/> N		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <b>John G. Orth, MD</b>				29c. LICENSE NUMBER <b>011795</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/20/96</b>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>JOHN G. ORTH 7505 OSLER DR. YOWSON, MD 21204</b>											
31. DATE FILED (Month, Day, Year) <b>FEB 22 1996</b>		32. REGISTRAR'S SIGNATURE <b>John A. Hurd</b>									

42240 21

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				96 04555							
1. DECEDECENT'S NAME (First, Middle, Last)				2. DATE OF DEATH				3. TIME OF DEATH							
Trifonia B. Gotis				Feb. 18 1996				1:54 A M							
4. SOCIAL SECURITY NUMBER		5. SEX		6. AGE (In yrs. last birthday)		7. DATE OF BIRTH		8. BIRTHPLACE (State or Foreign Country)							
217-19-6088		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		77 YRS.		Mar. 15, 1918		Philippines							
9a. FACILITY NAME (If not institution, give street and number)				9b. CITY, TOWN OR LOCATION OF DEATH				9c. COUNTY OF DEATH							
Howard County General Hospital				Columbia				Howard							
RESIDENCE OF DECEDECENT															
10a. STATE		10b. COUNTY		10c. CITY, TOWN OR LOCATION				10d. INSIDE CITY LIMITS?							
MD		Howard		Columbia				1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER				10f. ZIP CODE				10g. CITIZEN OF WHAT COUNTRY?							
6441 Mellow Wine Way				21044				Philippines							
11. MARITAL STATUS		12. WAS DECEDECENT EVER IN U.S. ARMED FORCES?		13. WAS DECEDECENT OF HISPANIC ORIGIN?		14. RACE — American Indian, Black, White, etc.									
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		Specify: Philippino		Specify: Philippino							
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		IF YES, GIVE WAR OR DATES													
15. DECEDECENT'S EDUCATION (Specify only highest grade completed)				16a. DECEDECENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY							
Elementary/Secondary (0-12) 12				College (1-4 or 5+) None				Homemaker				Own Home			
17. FATHER'S NAME (First, Middle, Last)						18. MOTHER'S NAME (First, Middle, Maiden Surname)									
Teodoro Barberan						Albina Cedeno									
19a. INFORMANT'S NAME (Type/Print)						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)									
Barbara Gotis						6400 Mellow Wine Way, Columbia, MD 21044									
20a. METHOD OF DISPOSITION				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)				20c. LOCATION — City or Town, State							
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State				Feb. 23, 1996				Catonsville, MD							
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				Metro Crematory											
21. SIGNATURE OF FUNERAL SERVICE LICENSEE				22. NAME AND ADDRESS OF FACILITY											
<i>Leroy &amp; Russell Witzke</i>				Leroy & Russell Witzke Funeral Home 5555 Twin Knolls Rd. Columbia, MD 21045											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.															
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute Hepatic failure															
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST															
Acute Renal failure															
SEPSIS															
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.															
HYPERTENSION															
24a. WAS AN AUTOPSY PERFORMED?				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?											
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO											
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
25. WAS CASE REFERRED TO MEDICAL EXAMINER?				26. PLACE OF DEATH (Check only one)											
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK?		28d. DESCRIBE HOW INJURY OCCURRED					
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				N/A		M		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		N/A					
				28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
				N/A				N/A							
29a. CERTIFIER (Check only one)															
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER						29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year)							
<i>N. B. Weller</i>						D. 30469		February 18, 1996							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)															
N. B. Weller No 9055 CHEVROLET DRIVE #100, ELICOTT CITY MD. 21042															
31. DATE FILED (Month, Day, Year)				32. REGISTRAR'S SIGNATURE											
FEB 22 1996				<i>Jake Davidson-Randall</i>											

52510 2

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 96 04556

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Harrison

2. Date of Death

February 21 1996

3. Time of Death

5:50 PM

4a. Facility Name (If not institution, give street and number)

Liberty Medical

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

216-20-2054

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

March 16, 1920

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

Maryland

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1909 Wheeler Ave.

10f. Zip Code

21216

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Afro-American

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

4+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Claims Adjustor

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Charles Henry Wright

18. Mother's Name (First, Middle, Maiden Surname)

Mary R. Moore

19a. Informant's Name/Relationship (Type, Print)

James W. Harrison

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1909 Wheeler Ave. Balto. Md. 21216

20a. Method of Disposition

1 ☒ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Greenmount/Mt. Zion (Land)

Date

2/27/96

20c. Location - City or Town, State

Balto. Md.

21. Signature of Funeral Service Licensee

Joseph L. Russ

22. Name and Address of Facility

Joseph L. Russ Funeral Home  
2222 W. North Ave. Balto. Md. 21216

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Ischemic Cardiomyopathy

Due to (or as a consequence of):

b. Pulmonary Edema

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

George E. Wicks III M.D.

29c. License number

D41365

29d. Date signed (Month, Day, Year)

February 21, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

George E. Wicks III M.D.

2600 Liberty Heights Ave 21216

31. Date filed (Month, Day, Year)

FEB 22 1996

32. Registrar's Signature

John Anderson

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



WRC  
96-0274-033  
UNK 96-006

Item 8 2-26-96 File # 732 W.H. Pac. A. Board  
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.  
ITEMS: 23 PART I, 27, State of Maryland / Department of Health and Mental Hygiene  
28a-f, PER MEO FILM G-733 3/4/96 t.t.  
Certificate of Death

Reg. No. 96 04557

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

HARDEN REESE HARRIS

2. Date of Death

JAN. 18, 1996

3. Time of Death

6:46 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

5400 INDIAN HEAD HWY

4b. City, Town, or Location of Death

OXON HILL

4c. County of Death

5. Social Security Number

unknown

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

72

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

AUG 2, 1923

9. Birthplace (State or Foreign Country)

unknown

Usual Residence of Decedent

10a. State

unknown

10b. County

unknown

10c. City, Town or Location

unknown

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

10e. Street and Number

unknown

10f. Zip Code

unknown

10g. Citizen of What Country?

unknown

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

unknown

unknown

unknown

unknown

17. Father's Name (First, Middle, Last)

unknown

18. Mother's Name (First, Middle, Maiden Surname)

unknown

19a. Informant's Name/Relationship (Type, Print)

unknown

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

unknown

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☒ Other (Specify State rem.)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Dir.

22. Name and Address of Facility

State Anatomy Board-655 W. Baltimore Street  
Rm. B026-Baltimore, Maryland 21201-1559

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

ENVIRONMENTAL HYPOTHERMIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):  
b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☒ Other (Specify)

27. Manner of Death

1 ☐ Natural  
2 ☒ Accident  
3 ☐ Suicide  
4 ☐ Homicide

5 ☐ Pending Investigation  
6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

FOUND 1/18/96

28b. Time of

FOUND 4:59 AM

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how Injury occurred

SUBJECT FOUND IN ABANDONED COLD GAS STATION

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

ABANDONED GAS STATION

28f. Location (Street and Number or Rural Route Number, City or Town, State)

5400 INDIAN HEAD HWY. OXON HILL, MD.

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☒ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

► [Signature]

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

JAN. 19, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARY PARRIS A. KORON 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

FEB 22 1996

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

[224] 完


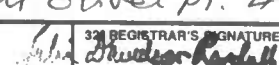


TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				96 04558			
CERTIFICATE OF DEATH				REG. NO.							
1. DECEDENT'S NAME (First, Middle, Last) <b>PATRICIA ANN HEINLEIN</b>				2. DATE OF DEATH MONTH <b>FEBRUARY</b> DAY <b>20</b> YEAR <b>1996</b>				3. TIME OF DEATH <b>2:00</b> M			
4. SOCIAL SECURITY NUMBER <b>212 78 3745</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>49</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>March 29, 1946</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>					
9a. FACILITY NAME (If not institution, give street and number) <b>Deaton Hospital &amp; Medical Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>				9c. COUNTY OF DEATH <b>N/A</b>			
RESIDENCE OF DECEDENT											
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Anne Arundel</b>		10c. CITY, TOWN OR LOCATION <b>Jessup</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER <b>7274 Cedar Avenue</b>				10f. ZIP CODE <b>20794</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>0</b> Elementary/Secondary (0-12)		15b. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Never Worked</b>		16. KIND OF BUSINESS/INDUSTRY <b>N/A</b>							
17. FATHER'S NAME (First, Middle, Last) <b>(unknown)</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Catherine Heinlein</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Catherine Cookus</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>516 Holy Cross Road Baltimore, Maryland 21225</b>							
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metro Crematory, Inc. 2/21</b>		20c. LOCATION — City or Town, State <b>Baltimore, Maryland</b>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>George J. Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225</b>							
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> a. <b>Urinary tract infection</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Malnutrition</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>Multiple wounds</b> DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death <b>5 days</b> <b>Yrs.</b> <b>Months</b>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/></b>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <b>cpuchita m</b>						29c. LICENSE NUMBER <b>D34974</b>		29d. DATE SIGNED (Month, Day, Year) <b>2-21-96</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>5865 Robert Oliver Pl. #121, Columbia, MD 21045</b>											
31. DATE FILED (Month, Day, Year) <b>FEB 22 1996</b>				32. REGISTRAR'S SIGNATURE 							

022:19 2

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				96 04559					
CERTIFICATE OF DEATH				REG. NO.									
1. DECEDENT'S NAME (First, Middle, Last) JAMES E. HAMILTON				2. DATE OF DEATH MONTH DAY YEAR FEB. 13 1996				3. TIME OF DEATH 1:05 P. M.					
4. SOCIAL SECURITY NUMBER 215-12-9574		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 72 YRS.		7. DATE OF BIRTH (Month, Day, Year) MAR. 11, 1923		8. BIRTHPLACE (State or Foreign Country) MARYLAND					
9a. FACILITY NAME (If not institution, give street and number) ANNE ARUNDEL MEDICAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH ANNAPOLIS				9c. COUNTY OF DEATH ANNE ARUNDEL					
10a. STATE MARYLAND				10b. COUNTY ANNE ARUNDEL		10c. CITY, TOWN OR LOCATION GLEN BURNIE				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 306 OXFORD DRIVE				10f. ZIP CODE 21061				10g. CITIZEN OF WHAT COUNTRY? UNITED STATES					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: WHITE					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) PROPERTY MANAGER				16b. KIND OF BUSINESS/INDUSTRY UNITED STATES ARMY					
17. FATHER'S NAME (First, Middle, Last) WILLIAM HAMILTON				18. MOTHER'S NAME (First, Middle, Maiden Surname) LILLIAN UNKNOWN									
19a. INFORMANT'S NAME (Type/Print) DONNA BAUNE				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6001 MANOR CT. N.E. ALBUQUERQUE, N.M. 87123									
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GLEN HAVEN MEM. PK. FEB. 17, 1996				20c. LOCATION — City or Town, State GLEN BURNIE, MD							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Cori L. Ebaugh				22. NAME AND ADDRESS OF FACILITY KIRKLEY-RUDDICK FUNERAL HOME 421 CRAIN HWY. S.E. GLEN BURNIE, MD 21061									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) →  Cardiac Standstill DUE TO (OR AS A CONSEQUENCE OF):  Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF):  Subdural Hematoma DUE TO (OR AS A CONSEQUENCE OF):  Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  Approximate Interval Between Onset and Death Instant 1 hour 25 days													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>				24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER R. I. Hochman MD		29c. LICENSE NUMBER D05192		29d. DATE SIGNED (Month, Day, Year) 2/20/96		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) R. I. Hochman MD - 18334 Forest Dr., Annapolis Md 21409		31. DATE FILED (Month, Day, Year) FEB 22 1996		32. REGISTRAR'S SIGNATURE John Andrew Randall	

10 + 1

2222

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.  
State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

Reg. No. 96 04560

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

RITA

HERBERT

2. Date of Death  
Month Day Year  
FEBRUARY 20 1996

3. Time of Death  
0135 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

5. Social Security Number

029-20-9793

6. Sex  
1 ☐ M ☒ F

7. Age (in yrs. last birthday)

67

If Under 1 Year  
Months Days

If Under 24 Hrs.  
Hours Min.

8. Date of Birth  
(Month, Day, Year)

Oct. 4, 1928

9. Birthplace (State or Foreign Country)

MASS

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

37 Farmhouse Court

10f. Zip Code

21208

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.  
Armed Forces?

1 ☐ Yes ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes ☒ No Specify:

14. Race - American Indian,  
Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Louis Garbowit

18. Mother's Name (First, Middle, Maiden Surname)

Esther Schwartz

19a. Informant's Name/Relationship (Type, Print)

Dr Norman Herbert (husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

37 Farmhouse Court Baltimore Md 21208

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Arlington Cem.

Date

Feb 21, 1996

20c. Location - City or Town, State

Baltimore MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SOL LEVINSON & BROS., INC.

6010 REISTERSTOWN ROAD BALTIMORE, MD 21215

23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final  
disease or condition  
resulting in death)

a. metastatic Breast Cancer

Approximate  
Interval Between  
Onset and Death

8 yrs

Due to (or as a consequence of):

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy  
performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings  
available prior to  
completion of cause  
of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical  
examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

27a. Date of Injury  
(Month, Day, Year)

27b. Time of  
injury

M \*

27c. Injury at  
Work?

1 ☐ Yes 2 ☐ No

27d. Describe how Injury occurred

27e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

27f. Location (Street and Number or Rural Route Number,  
City or Town, State)

29a. Certifier  
(Check only  
one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

W. A. Riley, MD

29c. License number

025205

29d. Date signed (Month, Day, Year)

2/20/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W. A. Riley, G. BMC 6701 N. Charles Street, Balto. MD 21204

31. Date filed (Month, Day, Year)

FEB 22 1996

0831

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ITEMS: 1. &amp; 18. PER F.H. FILM G-732 2/22/96 t.t

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04561

1. DECEDENT'S NAME (First, Middle, Last) <b>HAROLD CARTER HARRIS</b>				2. DATE OF DEATH MONTH DAY YEAR <b>Feb 20 96</b>		3. TIME OF DEATH <b>11 A M</b>	
4. SOCIAL SECURITY NUMBER <b>213-52-5395</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>47</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Sept 15 1948</b>	
8. BIRTHPLACE (State or Foreign Country) <b>VA</b>				9. COUNTY OF DEATH <b>BALTO</b>			
10. FACILITY NAME (If not institution, give street and number) <b>Mercy Hospital</b>				11. CITY, TOWN OR LOCATION OF DEATH <b>Balt. City</b>			
12. STATE <b>MD</b>				13. COUNTY <b>N/A</b>			
14. CITY, TOWN OR LOCATION <b>BALTIMORE</b>				15. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
16. STREET AND NUMBER <b>4320 CLAIRWAY DR APT 85</b>				17. ZIP CODE <b>21213</b>		18. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
19. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		20. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		21. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No - If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		22. RACE - American Indian, Black, White, etc. Specify: <b>BLACK</b>	
23. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10th</b> College (1-4 or 5+) <b>N/A</b>				24. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>TRUCK DRIVER</b>		25. KIND OF BUSINESS/INDUSTRY <b>HAMMOND ORGANN CO</b>	
26. FATHER'S NAME (First, Middle, Last) <b>SAM HARRIS</b>				27. MOTHER'S NAME (First, Middle, Maiden Surname) <b>EDITH WYATT</b>			
28. INFORMANT'S NAME (Type/Print) <b>EDITH HARRIS</b>				29. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4320 CLAIRWAY DR APT BALTO MD 21213</b>			
30. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		31. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>BALTO CEM FEB 26, 96 BALTO, MD</b>		32. LOCATION - City or Town, State		33. NAME AND ADDRESS OF FACILITY <b>BETTS FUNERAL HOME 1129 N. CAROLINE ST BALTO, MD 21213</b>	
34. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ARDS</b> <span style="float: right;">Approximate interval Between Onset and Death <b>1d</b></span>							
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <b>Sepsis</b> <span style="float: right;"><b>1d</b></span>							
<b>Pneumonia</b> <span style="float: right;"><b>1d</b></span>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>AIDS, liver Cirrhosis, Acute Renal failure</b>							
35. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>				36. 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		37. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
38. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				39. 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
40. 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		41. 28a. DATE OF INJURY (Month, Day, Year)		42. 28b. TIME OF INJURY <b>M</b>		43. 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
44. 28d. DESCRIBE HOW INJURY OCCURRED				45. 28e. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)			
46. 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				47. 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
48. 29b. SIGNATURE AND TITLE OF CERTIFIER <b>J. Ghiorzi</b>				49. 29c. LICENSE NUMBER <b>P 08667</b>		50. 29d. DATE SIGNED (Month, Day, Year) <b>2/20/96</b>	
51. 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Tom Ghiorzi 301 St. Paul St. Balt, MD</b>							
52. 31. DATE FILED (Month, Day, Year) <b>FEB 22 1996</b>				53. 32. REGISTRAR'S SIGNATURE <b>Julia Anderson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				96 04562	
		CERTIFICATE OF DEATH				REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last) Edward Michael Howard				2. DATE OF DEATH Feb. 19, 1996		3. TIME OF DEATH 10:55a m	
4. SOCIAL SECURITY NUMBER 215-24-5486		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 66 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 18, 1929	
8. BIRTHPLACE (State or Foreign Country) Maryland		9a. FACILITY NAME (If not institution, give street and number) 2825 Lodge Farm Road Apt. 317		9b. CITY, TOWN OR LOCATION OF DEATH Edgemere		9c. COUNTY OF DEATH Baltimore	
10a. STATE Maryland				10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Edgemere	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 2825 Lodge Farm Road Apt. 317		10f. ZIP CODE 21219	
10g. CITIZEN OF WHAT COUNTRY? USA				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Korean Conflict	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5 College (1-4 or 5+) 5				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Painter		16b. KIND OF BUSINESS/INDUSTRY Residential	
17. FATHER'S NAME (First, Middle, Last) Shirley Clifford Howard				18. MOTHER'S NAME (First, Middle, Maiden Surname) Thelma Louise Frey			
19a. INFORMANT'S NAME (Type/Print) Leon Gene Howard				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 330 Bigley Avenue Baltimore, MD 21227			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory, Inc. 02/20/96		20c. LOCATION — City or Town, State Baltimore, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dawn F. McDonald				22. NAME AND ADDRESS OF FACILITY Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) →  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. Coronary artery disease DUE TO (OR AS A CONSEQUENCE OF): b. Diabetes mellitus DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Severe peripheral vascular disease  DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER Joseph H. Hines		29c. LICENSE NUMBER D32158	
29d. DATE SIGNED (Month, Day, Year) Feb. 20, 1996				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Tyotin Parikh, MD 821 N. Eutaw St #407, Baltimore MD 21201			
31. DATE FILED (Month, Day, Year) FEB 22 1996				32. REGISTRAR'S SIGNATURE John H. Hines			

2000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04563

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>PAUL WILLIAM HOOVER</b>				2. Date of Death Month <b>JAN.</b> Day <b>30</b> , Year <b>1996</b>				3. Time of Death <b>17:30 P</b>						
	4a. Facility Name (If not institution, give street and number) <b>1140 DEXTER ST.</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>				4c. County of Death <b>N/A</b>						
Funeral Director	5. Social Security Number <b>214-50-4545</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>50</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>JULY 4, 1945</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>						
	Usual Residence of Decedent														
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						
	10e. Street and Number <b>1140 Dexter Street</b>				10f. Zip Code <b>21230</b>		10g. Citizen of What Country? <b>USA</b>								
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>							
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> Collage (1-4 or 5+) <b></b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Factory Worker</b>			16b. Kind of Business/Industry <b>Unknown</b>							
	17. Father's Name (First, Middle, Last) <b>Russell Hoover</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Edith Pearl Young</b>										
	19a. Informant's Name/Relationship (Type, Print) <b>Helen L. Bonnet/Sister</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3017 Sixth Ave. Baltimore, MD 21234</b>										
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory, Inc. 2/20/96</b>		Data <b></b>		20c. Location - City or Town, State <b>Baltimore, MD</b>								
	21. Signature of Funeral Service Licensee <b>Dawn F. McDonald</b>				22. Name and Address of Facility <b>Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228</b>										
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Atherosclerotic Cardiovascular disease</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>										Approximate Interval Between Onset and Death <b></b>				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b></b>										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year) <b></b>		28b. Time of injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred <b></b>							
28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify) <b></b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b></b>													
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										29b. Signature and title of certifier <b>[Signature]</b>		29c. License number <b>OCME</b>		29d. Date signed (Month, Day, Year) <b>JAN. 31, 1996</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>David R Fowler 111 Penn Street, Baltimore, Maryland 21201</b>															
31. Date filed (Month, Day, Year) <b>FEB 22 1996</b>		32. Registrar's Signature <b>[Signature]</b>													

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

227110



227110

96 04564

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>KAREN HANKEL</b>				2. DATE OF DEATH MONTH <b>FEB</b> DAY <b>18</b> YEAR <b>1996</b>		3. TIME OF DEATH <b>7:40 AM</b>	
4. SOCIAL SECURITY NUMBER <b>398-58-9338</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>42</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Oct. 9, 1953</b>	
8. FACILITY NAME (If not institution, give street and number) <b>Howard County General Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Columbia</b>		9c. COUNTY OF DEATH <b>Howard</b>	
10a. STATE <b>MD</b>				10b. COUNTY <b>Howard</b>		10c. CITY, TOWN OR LOCATION <b>Columbia</b>	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>9506 Dawnblush Court</b>			
10f. ZIP CODE <b>21045</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>5+</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Robert Hankel</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Maryon Awe</b>			
19a. INFORMANT'S NAME (Type/Print) <b>David G. Essig (Spouse)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9506 Dawnblush Court, Columbia, MD 21045</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Holy Cross Cemetery Feb. 24, 1996</b>		20c. LOCATION — City or Town, State <b>Milwaukee, Wisconsin</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>R. Co., Wyle &amp; Co.</b>				22. NAME AND ADDRESS OF FACILITY <b>Leroy &amp; Russell Witzke Funeral Home 5555 Twin Knolls Rd. Columbia, MD 21045</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>SEPSIS</b>							
a. DUE TO (OR AS A CONSEQUENCE OF):							
b. <b>STAPHYLOCOCCUS AUREUS BACTERAEMIA</b>							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ACUTE RESPIRATORY DISTRESS SYNDROME</b> <b>MAUNUTRITION</b> <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>David G. Essig</b>				29c. LICENSE NUMBER <b>D 36974</b>		29d. DATE SIGNED (Month, Day, Year) <b>FEB 18, 1996</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DAVID O. NYANJOM MD 5099 HARBERS FARM RD COLUMBIA MD 21044</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 22 1996</b>		32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

32 04261



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04565

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ALICE HALL

2. Date of Death

Month Day Year  
2/15/96

3. Time of Death

3:46 AM

4a. Facility Name (If not institution, give street and number)

(HOME) 1843 PRESSTMAN ST.

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTO. CITY

Funeral  
Director

5. Social Security Number

220 20 2895

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

67

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
3/4/28

9. Birthplace (State or Foreign Country)

CHESTER S.C.

Usual Residence of Decedent

10a. State

MD.

10b. County

BALTO. CITY

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2843 PRESSTMAN ST.

10f. Zip Code

21217

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HomeMAKER

16b. Kind of Business/Industry

HOME

17. Father's Name (First, Middle, Last)

LEE ANDREW HALL

18. Mother's Name (First, Middle, Maiden Surname)

LOUISE H. HALL

19a. Informant's Name/Relationship (Type, Print)

REBECCA MILLER SISTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1843 PRESSTMAN ST. BALTO. MD. 21217

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CEDAR HILL 2/20/96

Date

20c. Location - City or Town, State

BROOKLYN, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility  
ESTEP BROTHERS FUNERAL HOME P.A.  
1300 EUTAW PL. BALTO. MD. 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute cerebrovascular accident

Due to (or as a consequence of):

b. Atrial fibrillation

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Bilateral cerebrovascular accidents  
Peripheral vascular disease  
Degenerative arthritis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D28236

29d. Date signed (Month, Day, Year)

2/19/96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

DORIAN S ST MARTIN MD 5411 OR FREDERICK RD BALT MD 21229

31. Date filed (Month, Day, Year)

FEB 22 1996

32. Registrar's Signature

John Andrew Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 48 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial/transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 04566

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Thomas Franklin Jenkins Sr.

2. Date of Death

February 20 1996

Day Month Year

3. Time of Death

6:52 A.M.

4a. Facility Name (If not institution, give street and number)

Bayview Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

214 16 8779

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 31, 1923

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3306 Washington Blvd.

10f. Zip Code

21227

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: W.W. II

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
6th

College (1-4 or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

Trucking  
Transportation

17. Father's Name (First, Middle, Last)

Clarence Jenkins

18. Mother's Name (First, Middle, Maiden Surname)

Emma Clemens

19a. Informant's Name/Relationship (Type, Print)

Deborah Dowell

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

159 W. Meadow Road Baltimore, Maryland 21225

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Md. State Veteran Cem.

Date

2/23/96

20c. Location - City or Town, State

Crownsville, Maryland

21. Signature of Funeral Service Licensee

*Emma J. Zmurek*

22. Name and Address of Facility

Gonce Funeral Home P.A.

4001 Ritchie Highway Baltimore, Md. 21225

23a. Part I. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Respiratory failure

Approximate Interval Between Onset and Death

1 hr.

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Chronic Respiratory obstruction 10 yrs

Due to (or as a consequence of):

Disease

Due to (or as a consequence of):

Carcinoma Larynx

2 yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician

2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*S. K. K. K. K. K.*

29c. License number

007309

29d. Date signed (Month, Day, Year)

2/21/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3721 Potomac St. Baltimore, Md 21225

31. Date filed (Month, Day, Year)

FEB 22 1996

32. Registrar's Signature

*John J. K. K. K.*

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

8+1



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04567

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Eleanora Johnson</b>				2. Date of Death Month <b>February</b> Day <b>18</b> Year <b>1996</b>		3. Time of Death <b>12:30 pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>Liberty Medical Center</b>				4b. City, Town, or Location of Death <b>Balto</b>		4c. County of Death <b>NIA</b>	
Funeral Director	5. Social Security Number <b>218-26-6256</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>63</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Nov 28, 1932</b>	9. Birthplace (State or Foreign Country) <b>md</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>md</b>		10b. County <b>NIA</b>		10c. City, Town or Location <b>Balto</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <b>3017 Ferndale Ave</b>				10f. Zip Code <b>21207</b>		10g. Citizen of What Country? <b>U.S.A</b>	
	11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11<sup>th</sup></b> College (11-4or 5+) <b>NIA</b>		18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Nurses Assistance</b>		16b. Kind of Business/Industry <b>Hospital</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Richard Johnson</b>				18. Mother's Name (First, Middle, Maiden Summa) <b>Evelyn Jones</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Bryant Johnson son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3017 Ferndale Ave Balto, md 21207</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Garrison Forest vet</b>		20c. Location - City or Town, State <b>2/23/96 Owing mills md</b>			
	21. Signature of Funeral Service Licensee <b>Gabrielle Cook</b>		22. Name and Address of Facility <b>March F. H. West 4300 Wabash Ave</b>					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Coronary Artery Disease</b> Dua to (or as a consequence of): b. <b>Pulmonary Edema</b> Dua to (or as a consequence of): c. <b>Peripheral Vascular Disease</b> Dua to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death <b>Years</b> <b>10 hrs</b> <b>Years</b>
	Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. <b>Hypertension</b> <b>Diabetes Mellitus</b>							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
								24b. Were autopsy findings available prior to completion of causa of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
			28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how Injury occurred			
			28f. Location (Street and Number or Rural Route Number, City or Town, State)					
State Registrar	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>George E. Wicks III M.D.</b>		29c. License number <b>D41365</b>		29d. Date signed (Month, Day, Year) <b>February 18, 1996</b>	
	30. Name and address of person who completed causa of death (Item 23a) (Type, Print) <b>George E. Wicks III M.D. 2600 Liberty Heights Ave. 21215</b>							
	31. Date filed (Month, Day, Year) <b>FEB 22 1996</b>		32. Registrar's Signature <b>Julia Davidson-Randall</b>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Registrar or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Form 28

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 96 04568

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>PENNY KEYES</b>				2. Date of Death Month <b>FEBRUARY</b> Day <b>13</b> Year <b>1996</b>		3. Time of Death <b>10:10AM</b>	
4a. Facility Name (If not institution, give street and number) <b>THE JOHNS HOPKINS HOSPITAL</b>				4b. City, Town, or Location of Death <b>BALTIMORE CITY</b>		4c. County of Death <b>n/a</b>	
5. Social Security Number <b>155-56-6631</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>38</b> Yrs.		8. Date of Birth (Month, Day, Year)	
9. Birthplace (State or Foreign Country) <b>unknown</b>		10a. State <b>Maryland</b>		10b. County <b>n/a</b>		10c. City, Town or Location <b>Baltimore</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>3941 Penhurst Avenue</b>		10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input checked="" type="checkbox"/> Navar Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify <b>Black</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>unknown</b> College (1-4or 5+) <b>unknown</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>unknown</b>		16b. Kind of Business/Industry <b>unknown</b>		17. Father's Name (First, Middle, Last) <b>unknown</b>	
18. Mother's Name (First, Middle, Maiden Sumama) <b>unknown</b>		19a. Informant's Name/Relationship (Type, Print) <b>Shelly Harris (friend)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>unknown</b>		20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>State rem.</b>	
20b. Place of Disposition (Name of cemetery, crematory or other place) <b>State rem.</b>		20c. Location - City or Town, State		21. Signature of Funeral Service Licentiate <b>Ronald S. Wade, Dir.</b>		22. Name and Address of Facility <b>State Anatomy Board-655 W. Baltimore Street Rm. B026-Baltimore, Maryland 21201-1559</b>	
23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one causa on each line.  Immediate Causa (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <b>pneumocystis pneumonia</b> Due to (or as a consequence of):  b. <b>acquired immunodeficiency syndrome</b> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):		Approximate Interval Between Onset and Death  <b>2 weeks</b>  <b>4 years</b>		Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.  <b>persistent vegetative state</b>  <b>hyponatremia</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of causa of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicida <input type="checkbox"/> Homicida		28a. Date of Injury (Month, Day Year) <b>M</b>		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated.	
29b. Signature and title of certifier <b>SIA HUNG MD</b>		29c. License number <b>M8283</b>		29d. Date signed (Month, Day, Year) <b>February 13, 1996</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Sarah Hung MD Tower 110 Johns Hopkins Hospital</b>	
31. Data filed (Month, Day, Year) <b>FEB 22 1996</b>		32. Registrar's Signature <b>John A. ...</b>		33. Registrar's Title <b>Registrar</b>		34. Registrar's Office <b>State Registrar</b>	

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04569

1. DECEDENT'S NAME (First, Middle, Last) <b>HOSEA E. KAISER</b>				2. DATE OF DEATH MONTH DAY YEAR <b>FEB 17, 1996</b>		3. TIME OF DEATH <b>12:41 P</b>	
4. SOCIAL SECURITY NUMBER <b>254-14-0219</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>75</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Sept 30, 1920</b>	
8. BIRTHPLACE (State or Foreign Country) <b>GA.</b>				9. FACILITY NAME (If not institution, give street and number) <b>Bon Secours Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Balto</b>	
9c. COUNTY OF DEATH <b>N/A</b>				10a. STATE <b>md</b>		10b. COUNTY <b>N/A</b>	
10c. CITY, TOWN OR LOCATION <b>Balto</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>1032 N. Calhoun st.</b>	
10f. ZIP CODE <b>21217</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WWII</b>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (14 or 5+) <b>N/A</b>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Caterer</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Catering</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Homer Kaiser</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Ada Roberts</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Brenda Sullivan</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1816 Mosher st. Balto, md 21217</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Garrison Forest vet 4/23/96</b>			
20c. LOCATION — City or Town, State <b>Owing mills, md</b>				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Gabrielle Cook</b>			
22. NAME AND ADDRESS OF FACILITY <b>March A. H. - west 4300 Wabash Ave</b>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ASPIRATION</b>  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Metastatic adenocarcinoma</b> <b>Malnutrition</b> <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/></b>			
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) <b>M</b>			
28b. TIME OF INJURY <b>M</b>				28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Silmon MD</b>				29c. LICENSE NUMBER <b>D16263</b>			
29d. DATE SIGNED (Month, Day, Year) <b>FEB 17, 1996</b>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>JUAN A. BEUTRAN 1940 W. BALT. ST. BALT MD</b>			
31. DATE FILED (Month, Day, Year) <b>FEB 22 1996</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

6+1





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Per NH

State of Maryland / Department of Health and Mental Hygiene

Film G732 item 26 2-22-96 rja

Certificate of Death

Reg. No.

96 04570

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

HARRIET

KOERIN

2. Date of Death

Month Day Year  
FEB. 17, 1996

3. Time of Death

5pm

4a. Facility Name (If not institution, give street and number)

PIKESVILLE NURSING HOME

4b. City, Town, or Location of Death

PIKESVILLE

4c. County of Death

BALTIMORE

5. Social Security Number

215-03-2369

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
JUNE 1, 1911

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10e. State

MARYLAND

10b. County

BALTIMORE

10c. City, Town or Location

RANDALLSTOWN

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

8440 ALLENSWOOD ROAD

10f. Zip Code

21133

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

COPYWRITER

16b. Kind of Business/Industry

RETAIL

17. Father's Name (First, Middle, Last)

SAMUEL

FIELDMAN

18. Mother's Name (First, Middle, Maiden Surname)

HELEN

ROSENFELD

19a. Informant's Name/Relationship (Type, Print)

MR. STANLEY J. FIELDMAN (BROTHER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

914 OLMSTEAD ROAD BALTIMORE, MD 21208

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BETH EL MEMORIAL PARK - 2-20-1996- RANDALLSTOWN, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SOL LEVINSON &amp; BROS., INC.

6010 REISTERSTOWN ROAD BALTIMORE, MD 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute pulmonary edema + heart failure acute

b. Acute myocardial infarction - acute

c. Atherosclerotic cardiovascular disease 20 years

d.

Approximate Interval Between Onset and Death

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Multifactorial dementia, multiple cerebrovascular accidents, dysphagia

Multiple pressure sores of neck + foot

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined7 ☐ Pending investigation8 ☐ Could not be determined9 ☐ Pending investigation10 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Place of Injury - At home, term, street, factory, office building, etc. (Specify)

28e. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D-16090

29d. Date signed (Month, Day, Year)

2/19/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Herbert Gerald Oster MD 3635 Old Court Rd. Pikesville MD

31. Date filed (Month, Day, Year)

FEB 22 1996

32. Registrar's Signature

FEB 22 1996

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

96 04571

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MOLLIE H. KERN</b>				2. DATE OF DEATH MONTH DAY YEAR <b>FEBRUARY 19, 1996</b>		3. TIME OF DEATH <b>8:45 P M</b>	
4. SOCIAL SECURITY NUMBER <b>219-14-0183</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>80</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>March 28, 1915</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Brooke Grove Rehab</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Olney</b>	
9c. COUNTY OF DEATH <b>Montgomery</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>	
10c. CITY, TOWN OR LOCATION <b>Olney</b>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>17500 Princess Anne Drive</b>	
10f. ZIP CODE <b>20832</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>12</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Clerk</b>		16b. KIND OF BUSINESS/INDUSTRY <b>State Of Maryland</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Frank Hoffman</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Katie Smith</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Judy Thomas (Daughter)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>17500 Princess Anne Dr Olney MD 20832</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Adath Yeshurun (Sodova) Feb 21, 1996 Baltimore MD</b>		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael Dwyer</i>				22. NAME AND ADDRESS OF FACILITY <b>SOL LEVINSON &amp; BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>SEPTIC SHOCK</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>PNEUMONIA</b> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death <b>48 HOURS</b> <b>3 WEEKS</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>J. Edwards</i>				29c. LICENSE NUMBER <b>D33700</b>		29d. DATE SIGNED (Month, Day, Year) <b>FEBRUARY 20, 1996</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Ted E. Howe, M. D. 18100 Slade School Road Sandy Spring, Maryland 20860</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 22 1996</b>				32. REGISTRAR'S SIGNATURE <i>John Anderson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

15240 2

2000-0000 0000 0000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

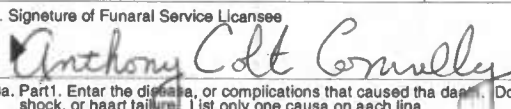
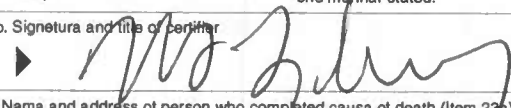
State of Maryland / Department of Health and Mental Hygiene

Item 1, Film 732, 2/22/96, 1t

## Certificate of Death

Reg. No.

96 04572

Physician /Medical Examiner	1. Decedant's Name (First, Middle, Last) <b>Stephen STEPHEN KOD</b>				2. Date of Death Month Day Year <b>February 19, 1996</b>		3. Time of Death <b>4:10 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Franklin Square Hospital</b>				4b. City, Town, or Location of Death <b>N/A</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>213-20-5563</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>69</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Dec 17, 1926</b>	
	9. Birthplace (State or Foreign Country) <b>New Jersey</b>		10a. State <b>Md</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Edgemere</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>2825 Lodge Farm Rd</b>		10f. Zip Code <b>21219</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1945</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+) <b>Bricklayer</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry <b>Baltimore County</b>			
	17. Father's Name (First, Middle, Last) <b>Jacob Kod</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Unknown</b>		19a. Informant's Name/Relationship (Type, Print) <b>Dorothy Kod / wife</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2825 Lodge Farm Rd Baltimore, Md 21219</b>	
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory</b>		20c. Location - City or Town, State <b>2/22/96 Catonsville, Md</b>			
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Connelly Funeral Home of Dundalk 7110 Sollers Point Rd 21222</b>		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>e. Hemorrhagic shock</b> Due to (or as a consequence of):		Approximate Interval Between Onset and Death <b>4 hours</b>	
	23a. Part 2. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>b. Gastrointestinal bleeding</b> Due to (or as a consequence of):						<b>2 weeks</b>	
	23a. Part 3. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>c. Dementia</b> Due to (or as a consequence of):							
	23a. Part 4. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>d. Insulin dependent diabetes mellitus</b> Due to (or as a consequence of):							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Recent pneumonia</b> <b>Insulin dependent diabetes mellitus</b> <b>Dementia</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>D 27315</b>		29d. Date signed (Month, Day, Year) <b>2-19-96</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. M L Frydenborg 9000 Franklin Square Dr. Baltimore, Maryland 21237</b>								
31. Date filed (Month, Day, Year) <b>FEB 22 1996</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 04573

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Lila Ruth LEAKE

2. Date of Death  
Month Day Year

February 20, 1996

3. Time of Death

3:06 pm

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital

4b. City, Town, or Location of Death

N/A

4c. County of Death

Baltimore County

Funeral  
Director

5. Social Security Number

215-24-1983

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Jan. 6 1921

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

1552 Northbourne Road

10f. Zip Code

21239

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) College (1-4 or 5+)  
Secondary

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOUSEKEEPING

16b. Kind of Business/Industry

Holly Meryes Furniture

17. Father's Name (First, Middle, Last)

Samuel Martin

18. Mother's Name (First, Middle, Maiden Surname)

Celeoney Martin

19a. Informant's Name/Relationship (Type, Print)

Pernell Leak Sr./ Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9903 Marriottsville Rd., Severna Park, Md. 21133

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Greater Diggs Meth. Ch.

Date

2-25-96

20c. Location - City or Town, State

Rockingham, N.C.

21. Signature of Funeral Service Licensee

*Hai G. Close*

22. Name and Address of Facility

WILLIAM C. BROWN COMMUNITY F/H  
1206 North Avenue

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction

Approximate Interval Between Onset and Death

> 5 yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Atrial Fibrillation

> 5 yr

c. CHF

> 5 yr

d. HTN

> 5 yr

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

*[Signature]*

29c. License number

D41901

29d. Date signed (Month, Day, Year)

2/22/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ZIAD R. MIRZA 3007 E. NORTHERN PKWY 21214

31. Date filed (Month, Day, Year)

FEB 22 1996

32. Registrar's Signature

*[Signature]*

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

11



Certificate of Death

Reg. No. 96 04574

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>SANDRA MILDRED LEMARR</b>				2. Date of Death Month Day Year <b>FEB. 05, 1996</b>		3. Time of Death <b>12:15 PM</b>	
	4a. Facility Name (If not Institution, give street and number) <b>4142 bunker HILL RD.</b>				4b. City, Town, or Location of Death <b>COTTAGE CITY</b>		4c. County of Death <b>Prince George's</b>	
<b>Funeral Director</b>	5. Social Security Number <b>216-64-1675</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>44</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Feb. 17, 1951</b>	
	9. Birthplace (State or Foreign Country) <b>Dist. of Columbia</b>		10a. State <b>Maryland</b>		10b. County <b>Prince George's</b>		10c. City, Town or Location <b>Cottage</b>	
<b>To Be Completed by Funeral Director</b>	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>4142 Bunker Hill Road</b>		10f. Zip Code <b>20745</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify <b>Native American</b>	
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) unknown</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Housewife and Nurses Aide</b>		16b. Kind of Business/Industry <b>Various</b>			
	17. Father's Name (First, Middle, Last) <b>William Chudes</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Emily Prantis</b>					
	19a. Informant's Name/Relationship (Type, Print) (cousin) <b>unknown Chudes</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>unknown</b>					
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>State rem.</b>		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date		20c. Location - City or Town, State	
	21. Signature of Funeral Service Licensee <i>Ronald Wade</i>		22. Name and Address of Facility <b>State Anatomy Board-655 W. Baltimore Street Rm.B026-Baltimore, Maryland 21201-1559</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. HYPERTENSIVE CARDIOVASCULAR DISEASE</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	
28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Theodore H. King</i>		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>FEB. 06, 1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>THEODORE H. KING</b>		31. Date filed (Month, Day, Year) <b>FEB 22 1996</b>		Registrar's Signature <i>John A. ...</i>				
31. Date filed (Month, Day, Year) <b>FEB 22 1996</b>								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04575

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Margaret Helen Lovell

2. Date of Death

Month Day Year  
Feb. 18, 1996

3. Time of Death

1:06 A.M.

4a. Facility Name (If not institution, give street and number)

Carroll County General Hospital

4b. City, Town, or Location of Death

Westminster

4c. County of Death

Carroll

Funeral  
Director

5. Social Security Number

218 28 4180

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

62 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Sept. 26, 1933

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Carroll

10c. City, Town or Location

Sykesville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

105 Schoolhouse Road

10f. Zip Code

21784

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
8College (1-4 or 5+)  
--

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Unk.

18. Mother's Name (First, Middle, Maiden Surname)

Unk.

19a. Informant's Name/Relationship (Type, Print)

Richard A. Lovell

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

30 Lexington Dr. Fairview Heights, Ill 62208

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Pipe Creek Cemetery

Date

2/21/96

20c. Location - City or Town, State

New Windsor, Md.

21. Signature of Funeral Service Licensee

Harry W. Haight

22. Name and Address of Facility

Haight Funeral Home

P.O. Box 195 Sykesville, Md. 21784

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Ventricular Fibrillation

Due to (or as a consequence of):

b. Atherosclerotic cardiovascular disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Instant

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ BOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Chitachedu Naganu

29c. License number

015 200

29d. Date signed (Month, Day, Year)

2/18/96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Chitachedu Naganu 700-A Pool Rd Westminster MD 21157

31. Date filed (Month, Day, Year)

FEB 22 1996

32. Registrar's Signature

Chitachedu Naganu

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

2571

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

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1001. 1002. 1003. 1004. 1005. 1006. 1007. 1008. 1009. 1010. 1011. 1012. 1013. 1014. 1015. 1016. 1017. 1018. 1019. 1020. 1021. 1022. 1023. 1024. 1025. 1026. 1027. 1028. 1029. 1030. 1031. 1032. 1033. 1034. 1035. 1036. 1037. 1038. 1039. 1040. 1041. 1042. 1043. 1044. 1045. 1046. 1047. 1048. 1049. 1050. 1051. 1052. 1053. 1054. 1055. 1056. 1057. 1058. 1059. 1060. 1061. 1062. 1063. 1064. 1065. 1066. 1067. 1068. 1069. 1070. 1071. 1072. 1073. 1074. 1075. 1076. 1077. 1078. 1079. 1080. 1081. 1082. 1083. 1084. 1085. 1086. 1087. 1088. 1089. 1090. 1091. 1092. 1093. 1094. 1095. 1096. 1097. 1098. 1099. 1100.

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 96 04576

|  |  |  |   |   |   |  |  |  |
|--|--|--|---|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br>TONI LIVINGSTON  |  |   |   | 2. Date of Death<br>Month Day Year<br>FEBRUARY 19, 1996   |  | 3. Time of Death<br>7:30 PM  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>THE JOHNS HOPKINS HOSPITAL   |  |   |   | 4b. City, Town, or Location of Death<br>BALTIMORE CITY  |  | 4c. County of Death<br>N/A   |  |
| Funeral<br>Director  | 5. Social Security Number<br>217-66-5497   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>38 Yrs.   | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br>MAY 30, 1957  |  | 9. Birthplace (State or Foreign Country)<br>MD |
|  | Usual Residence of Decedent  |  |   |   |   |  |  |  |
| To Be Completed by Funeral Director                                  | 10a. State<br>MD   | 10b. County<br>N/A   | 10c. City, Town or Location<br>BALTIMORE  |   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |
|  | 10e. Street and Number<br>2040 EAGER ST  |  |   | 10f. Zip Code<br>21213  |   | 10g. Citizen of What Country?<br>U.S.A.  |  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: BLACK                     |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>12th N/A   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>UNEMPLOYEED                              |   | 18b. Kind of Business/Industry<br>N/A   |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>THOMAS SIMMS SR.  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>DORETHA SIMMS  |  |  |  |
| Physician<br>/Medical<br>Examiner                                    | 19e. Informant's Name/Relationship (Type, Print)<br>HARRY LIVINGSTON   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2040 E. EAGER ST BALTO, MD 21213 |   |  |  |  |
|  | 20e. Method of Disposition<br>3 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>BALTIMORE CEM   |   | Date<br>FEB 23, 96  |  | 20c. Location - City or Town, State<br>BALTO, MD                                     |  |
|  | 21. Signature of Funeral Service Licensee<br>  |  |   | 22. Name and Address of Facility<br>BETTS FUNERAL HOME<br>1129 N. CAROLINE ST BALTO, MD 21213                                     |   |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. FUNGAL SEPSIS<br>Due to (or as a consequence of):<br>b. AIDS<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br><br>Approximate Interval Between Onset and Death<br>7 DAYS<br>2 YEARS |  |   |   |   |  |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>RENAL FAILURE  |  |   |   |   |  |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|  |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28d. Describe how injury occurred   |  |  |  |
|  |  |  |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
|  | 29e. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |   |   |  |  |  |
| State Registrar  | 29b. Signature and title of certifier<br>  |  |   | 29c. License number<br>M7387  |   | 29d. Date signed (Month, Day, Year)<br>FEBRUARY 19, 1996   |  |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>DR. EMIL HAYEK, M.D. 600 NORTH WOLFE STREET, BALTIMORE, MARYLAND   |  |   |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br>FEB 22 1996                     |  |  |   |   |   |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04577

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Raven Nelson

2. Date of Death  
Month Day Year

2 17 96

3. Time of Death

11:20 AM

4a. Facility Name (If not institution, give street and number)

5509 Peerless Ave

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

city

Funeral  
Director

5. Social Security Number

219 19 6599

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

7 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year

April 17, 1988

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5509 PEERLESS AVE.

10f. Zip Code

21207

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

2ND

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

CHILD

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

PURVIS L L NELSON

18. Mother's Name (First, Middle, Maiden Surname)

VALARIE JOHNSON

19a. Informant's Name/Relationship (Type, Print)

VALARIE JOHNSON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5509 PEERLESS AVE. BALT. MD. 21207

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

KING MEM. PK.

Date

2/21/96

20c. Location - City or Town, State

RANDALLSTOWN MD.

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

GARY E. MARCH FUNERAL HOME P.A.  
270 FRED HILTON PASS BALT. MD. 21219

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory failure (hypoxia)

Due to (or as a consequence of):

b. Polymicrobial sepsis, treated

Due to (or as a consequence of):

c. AIDS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature] Physician

29c. License number

on file  
614 0732

29d. Date signed (Month, Day, Year)

2/17/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rodney Wilboughs MD 600 N. Wolfe St Baltimore MD 21287

31. Date filed (Month, Day, Year)

FEB 22 1996

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





ITEM: 23 PART I, PER DR. FILM G-733 3/16/96 t.t  
ITEMS: 28a,28c,28d,28e, PER DR. FILM G-732 2/22/96 t.t

FOR  
STATE  
REGISTRAR

DELETED

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04578

|   |  |  |  |   |  |   |                            |   |  |   |  |
|---|--|--|--|---|--|---|----------------------------|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Rodney Clarke Mann  |  |  |  | 2. DATE OF DEATH<br>MONTH 1 DAY 22 YEAR 1996  |  | 3. TIME OF DEATH<br>3:00 A M  |                            |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br>237-60-7611  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>55 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>6 22 1940  |                            | 8. BIRTHPLACE (State or Foreign Country)<br>N.Carolina  |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>219 S. Wolfe St.  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore  |  |   | 9c. COUNTY OF DEATH<br>N/A |   |  |   |  |
| 10a. STATE<br>Maryland  |  |  |  | 10b. COUNTY<br>N/A  |  | 10c. CITY, TOWN OR LOCATION<br>Baltimore  |                            | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO       |  |   |  |
| 10e. STREET AND NUMBER<br>219 S. Wolfe St.  |  |  |  | 10f. ZIP CODE<br>21231  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |                            |   |  |   |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                             |                            |   |  |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 years<br>College (14 or 5+) N/A   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Chief Stewart  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Military Sealift Command  |  |   |                            |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Elbert Mann  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Ethel Lassiter   |  |   |                            |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Gary Schroder   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>219 S. Wolfe St., Baltimore, MD 21231  |  |   |                            |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Green Mount Cemetery 1/23/96 Baltimore, MD  |  | 20c. LOCATION — City or Town, State   |  | 20d. DATE<br>1/23/96  |                            |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Catherine M Zeiler</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Lilly & Zeiler, Inc. Funeral Home<br>1901 Eastern Ave., Balto., MD 21231  |  |   |                            |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. <i>Respiratory Failure</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <i>Progressive Multifocal Leukoencephalopathy (PML)</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <i>Terminal Acquired Immunodeficiency Syndrome</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. <i>Emphysema</i><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |   |                            | Approximate Interval Between Onset and Death  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |   |                            | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  |   |  |   |                            |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |                            |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>a <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)<br>1/22/96  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |                            | 28d. DESCRIBE HOW INJURY OCCURRED<br>N/A  |  |   |  |
|   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br>Home   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                    |                            |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Carlos Page</i>  |  |   |  | 29c. LICENSE NUMBER<br>D37299   |                            | 29d. DATE SIGNED (Month, Day, Year)<br>1/22/96  |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Carlos Page, MD, 101 W. Read St., Baltimore, MD 21201  |  |  |  |   |  |   |                            |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>FEB 22 1996  |  | 32. REGISTRAR'S SIGNATURE<br><i>John A. ...</i>  |  |   |  |   |                            |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. DECEASED'S NAME (First, Middle, Last)   |  |  |  | 2. DATE OF DEATH   |  |                                |  | 3. TIME OF DEATH  |  |  |  |   |  |
|--|--|--|--|--|--|--------------------------------|--|---|--|--|--|---|--|
| 4. SOCIAL SECURITY NUMBER  |  |  |  | 5. SEX   |  | 6. AGE (In yrs. last birthday) |  | 7. DATE OF BIRTH  |  | 8. BIRTHPLACE (State or Foreign Country) |  |   |  |
| 9a. FACILITY NAME (If not Institution, give street and number)   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH  |  |                                |  | 9c. COUNTY OF DEATH   |  |  |  |   |  |
| 10a. STATE   |  |  |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION    |  |   |  | 10d. INSIDE CITY LIMITS?                 |  |   |  |
| 10e. STREET AND NUMBER   |  |  |  | 10f. ZIP CODE  |  |                                |  | 10g. CITIZEN OF WHAT COUNTRY?   |  |  |  |   |  |
| 11. MARITAL STATUS   |  |  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?  |  |                                |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) |  |  |  | 14. RACE — American Indian, Black, White, etc. Specify: |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)   |  |                                |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)  |  |                                |  |   |  |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)  |  |                                |  |   |  |  |  |   |  |
| 20a. METHOD OF DISPOSITION   |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)  |  |                                |  | 20c. LOCATION — City or Town, State   |  |  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  |  |  |  | 22. NAME AND ADDRESS OF FACILITY   |  |                                |  |   |  |  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  | Approximate Interval Between Onset and Death   |  |                                |  |   |  |  |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  |  |  | s. <u>Ventricular Fibrillation</u>   |  |                                |  | 30 mins   |  |  |  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST   |  |  |  | b. <u>Cardiomyopathy</u>   |  |                                |  | 3 years   |  |  |  |   |  |
|  |  |  |  | c. <u>N/A</u>  |  |                                |  |   |  |  |  |   |  |
|  |  |  |  | d. <u>N/A</u>  |  |                                |  |   |  |  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?   |  |                                |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?                                 |  |  |  |   |  |
| <u>Diabetes Mellitus with hypoglycaemia</u>  |  |  |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |                                |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                     |  |  |  |   |  |
| <u>Chronic Asthma with respiratory failure</u>   |  |  |  |  |  |                                |  |   |  |  |  |   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |  |  |  |                                |  |   |  |  |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?   |  |  |  | 26. PLACE OF DEATH (Check only one)  |  |                                |  |   |  |  |  |   |  |
| 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                |  |   |  |  |  |   |  |
| 27. MANNER OF DEATH  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY            |  | 28c. INJURY AT WORK?  |  | 28d. DESCRIBE HOW INJURY OCCURRED        |  |   |  |
| 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |  |  |  | <u>N/A</u>   |  | <u>N/A</u> M                   |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                     |  | <u>N/A</u>                               |  |   |  |
|  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |                                |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                |  |  |  |   |  |
|  |  |  |  | <u>N/A</u>   |  |                                |  | <u>N/A</u>  |  |  |  |   |  |
| 29a. CERTIFIER (Check only one)  |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER  |  |                                |  |   |  |  |  |   |  |
| 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  | 29c. LICENSE NUMBER  |  |                                |  |   |  |  |  |   |  |
| 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  | 29d. DATE SIGNED (Month, Day, Year)  |  |                                |  |   |  |  |  |   |  |
|  |  |  |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 24) (Type, Print)  |  |                                |  |   |  |  |  |   |  |
|  |  |  |  | <u>BERNARD P. FARRELL MD 11055 Little Patuxent Pkwy, Columbia, Md. 21044</u>   |  |                                |  |   |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)  |  |  |  | 32. REGISTRAR'S SIGNATURE  |  |                                |  |   |  |  |  |   |  |
| <u>FEB 22 1996</u>   |  |  |  | <u>Johanna...</u>  |  |                                |  |   |  |  |  |   |  |

92540 22

22540 22

REG. NO.

DHMH-16 Rev 1/89

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

10

08240 29

*Handwritten signature or mark*

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

Reg. No. **96 04581**

**Physician /Medical Examiner**

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician /Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

|   |  |   |                                |   |  |
|---|--|---|--------------------------------|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>CLEVELAND NATHANIEL MARINE SR</b>  |  | 2. Date of Death<br>Month <b>FEB</b> Day <b>19</b> Year <b>1996</b>   |                                | 3. Time of Death<br><b>11:00a</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>5340 PERRING PARKWAY</b>   |  | 4b. City, Town, or Location of Death<br><b>BALTO</b>  |                                | 4c. County of Death<br><b>N/A</b>   |  |
| 5. Social Security Number<br><b>247-09-8048</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>83</b> Yrs.  | If Under 1 Year<br>Months Days | 8. Date of Birth (Month, Day, Year)<br><b>dec 22, 1912</b>  | 9. Birthplace (State or Foreign Country)<br><b>SC</b>  |
| Usual Residence of Decedent   |  |   |                                |   |  |
| 10a. State<br><b>MD</b>   | 10b. County<br><b>N/A</b>  | 10c. City, Town or Location<br><b>BALTIMORE</b>   |                                | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| 10e. Street and Number<br><b>5340 PERRING PARKWAY</b>   |  | 10f. Zip Code<br><b>21239</b>   |                                | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8th</b> Collage (1-4or 5+) <b>N/A</b>   |                                |   |  |
| 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>STEEL WORKER</b>   |  | 16b. Kind of Business/Industry<br><b>SHIPYARD STEEL</b>   |                                |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>ELYARD MARINE SR</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>DAISY BELL CELLARS</b>  |                                |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>CARL LEE</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5340 PERRING PKWY BALTO, MD 21239</b>   |                                |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>ARBUTUST MEM PK</b>  |                                | 20c. Location - City or Town, State<br><b>FEB 23, 96 ARBUTUS, MD</b>  |  |
| 21. Signature of Funeral Service Licensee<br><i>Patricia Betts</i>  |  | 22. Name and Address of Facility<br><b>BETTS FUNERAL HOME<br/>1129 N. CAROLINE ST BALTO, MD 21213</b>   |                                |   |  |
| 23a. Pertinent. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. ISCHEMIC CARDIOMYOPATHY</b><br>Due to (or as a consequence of):<br><b>b. ASCVD</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b> |  |   |                                |   | Approximate Interval Between Onset and Death<br><b>5 year</b><br><b>5 yr</b>   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Congestive heart failure</b><br><b>Chronic Renal failure</b><br><b>Lung man</b>  |  |   |                                |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |                                |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |                                | 28b. Time of Injury<br><b>M</b>   |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  | 28d. Describe how Injury occurred   |                                |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |                                |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |                                |   |  |
| 29b. Signature and title of certifier<br><i>John T. Smith</i>   |  | 29c. License number<br><b>D26256</b>  |                                | 29d. Date signed (Month, Day, Year)<br><b>2/21/96</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>BICH DUONG, MD 700 Washington Blvd, Balto MD 21230</b>   |  |   |                                |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 22 1996</b>   |  | 32. Registrar's Signature<br><i>John T. Smith</i>   |                                |   |  |

1871



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 96 04582

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mattie Jane Milter

2. Date of Death

Month Day Year  
Feb. 18, 1996

3. Time of Death

1:30 A.M.

4a. Facility Name (If not institution, give street and number)

Sykesville Elder Care Center

4b. City, Town, or Location of Death

Sykesville

4c. County of Death

Carroll

5. Social Security Number

213 30 9832

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
June 21, 1915

9. Birthplace (State or Foreign Country)

Tenn.

Usual Residence of Decedent

10a. State

Md.

10b. County

Carroll

10c. City, Town or Location

Sykesville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3937 London Bridge Road

10f. Zip Code

21784

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No -

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

---

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Sales

16b. Kind of Business/Industry

Bendix &amp; May Co.

17. Father's Name (First, Middle, Last)

Clyde Lawson

18. Mother's Name (First, Middle, Maiden Surname)

Edna Collins

19a. Informant's Name/Relationship (Type, Print)

Kenneth E. Milter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3937 London Bridge Rd. Sykesville, Md. 21784

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Testerman Cemetery

Date

2/21/96

20c. Location - City or Town, State

Kyles Ford, Tenn

21. Signature of Funeral Service Licensee

Harry W. Haight

22. Name and Address of Facility

Haight Funeral Home

P.O. Box 195 Sykesville, Md. 21784

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure  
Due to (or as a consequence of):b. Myocardial Infarction  
Due to (or as a consequence of):c. Coronary Artery Disease  
Due to (or as a consequence of):

d. Hypertension

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Breast Cancer, Schizophrenia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

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28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Alexander B. [Signature]

29c. License number

D3794a

29d. Date signed (Month, Day, Year)

Feb. 14, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alexander B. [Signature] 1425 Liberty Rd. Suite #208, Eldersburg, Md 21784

31. Date filed (Month, Day, Year)

FEB 22 1996

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 96 04583

Physician  
/Medical  
Examiner

Funeral  
Director

|  |  |   |  |  |                                |  |   |
|--|--|---|--|--|--------------------------------|--|---|
| 1. Decedent's Name (First, Middle, Last)<br><b>THELMA M. NORRIS</b>  |  |   |  | 2. Date of Death<br>Month <b>2</b> Day <b>11</b> Year <b>96</b>  |                                | 3. Time of Death<br><b>11:16 PM</b>  |   |
| 4a. Facility Name (If not institution, give street and number)<br><b>NORTHWEST MEDICAL CENTER</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>RANDALLSTOWN</b>  |                                | 4c. County of Death<br><b>BALTO, CO.</b>   |   |
| 5. Social Security Number<br><b>243 20 8935</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>71</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><b>7/2/24</b>   | 9. Birthplace (State or Foreign Country)<br><b>N.C.</b> |
| Usual Residence of Decedent  |  |   |  |  |                                |  |   |
| 10a. State<br><b>MD.</b>   |  | 10b. County<br><b>BALTO.</b>  |  | 10c. City, Town or Location<br><b>RANDALLSTOWN</b>   |                                | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |
| 10e. Street and Number<br><b>171 PITTSTON CIRCLE</b>   |  |   |  | 10f. Zip Code<br><b>21117</b>  |                                | 10g. Citizen of What Country?<br><b>USA</b>  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>AFR. AMERICAN</b>  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>0</b>   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  |                                | 16b. Kind of Business/Industry<br><b>Home</b>  |   |
| 17. Father's Name (First, Middle, Last)<br><b>WILLIAM PETTIFORD</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>RACHEL GREGORY</b>   |                                |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>NOREEN NORRIS NEICE</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>171 PITTSTON CIR, OWINGS MILLS, MD. 21117</b>  |                                |  |   |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>KING, S PARK 2/15/96</b>   |  | Date<br><b>2/15/96</b>   |                                | 20c. Location - City or Town, State<br><b>RANDALLSTOWN, MD.</b>  |   |
| 21. Signature of Funeral Service Licensee<br><i>Beal C. Estep</i>  |  |   |  | 22. Name and Address of Facility<br><b>ESTEP BROTHERS FUNERAL HOME P.A.<br/>1300 EUTAW PL. BALTO. MD. 21217</b>  |                                |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><br>e. <b>Lung Cancer</b><br>Due to (or as a consequence of):<br>b. <b>Chronic Lung Disease</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br><br>Approximate Interval Between Onset and Death<br><b>5 years</b><br><b>10 years</b> |  |   |  |  |                                |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |                                | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |
|  |  |   |  |  |                                | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |
|  |  |   |  |  |                                | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |                                |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |
|  |  |   |  | 28d. Describe how injury occurred  |                                | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |
|  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |                                |  |   |
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |  |                                |  |   |
| 29b. Signature and title of certifier<br><i>Philip Konits</i>  |  |   |  | 29c. License number<br><b>D24321</b>   |                                | 29d. Date signed (Month, Day, Year)<br><b>2/13/96</b>  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>PHILIP KONITS 2059 BALTIMORE BLVD WESTMINSTER, MARYLAND 21048</b>   |  |   |  |  |                                |  |   |
| 31. Date filed (Month, Day, Year)<br><b>FEB 22 1996</b>  |  |   |  | 32. Registrar's Signature<br><i>Julia Anderson-Randall</i>   |                                |  |   |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

State  
Registrar

28210 2

1. The first part of the report  
describes the general situation  
of the country.

2. The second part of the report  
describes the general situation  
of the country.

3. The third part of the report  
describes the general situation  
of the country.

4. The fourth part of the report  
describes the general situation  
of the country.

5. The fifth part of the report  
describes the general situation  
of the country.

6. The sixth part of the report  
describes the general situation  
of the country.

7. The seventh part of the report  
describes the general situation  
of the country.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 96 04584

|  |   |  |   |  |  |
|--|---|--|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>HERMAN</b>   |  | 2. Date of Death<br>Month <b>JANUARY</b> Day <b>30</b> Year <b>1996</b>   |  | 3. Time of Death<br><b>3:30 P.M.</b>   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>3112 RICHWOOD AVE</b>  |  | 4b. City, Town, or Location of Death<br><b>WOODLAWN</b>   |  | 4c. County of Death<br><b>BALTIMORE</b>  |
| Funeral<br>Director  | 5. Social Security Number<br><b>unknown</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>66</b> Yrs.  | If Under 1 Year<br>Months Days                                 | If Under 24 Hrs.<br>Hours Min.   |
|  | 8. Date of Birth (Month, Day, Year)<br><b>July 9, 1929</b>  |  |   |  |  |
| To Be Completed by Funeral Director  | Usual Residence of Decedent   |  |   |  |  |
|  | 10a. State<br><b>Maryland</b>   | 10b. County<br><b>Baltimore</b>  | 10c. City, Town or Location<br><b>Woodlawn</b>  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
|  | 10e. Street and Number<br><b>3113 Richwood Avenue</b>   |  | 10f. Zip Code<br><b>21244</b>   |  | 10g. Citizen of What Country?<br><b>unknown</b>  |
|  | 11. Marital Status <b>unknown</b><br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces? <b>unknown</b><br><input type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>unknown</b> College (1-4 or 5+) <b>unknown</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>unknown</b>                           |  | 16b. Kind of Business/Industry<br><b>unknown</b>   |
|  | 17. Father's Name (First, Middle, Last)<br><b>unknown</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>unknown</b>   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Warren Wilson (friend)</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>unknown</b>                                       |  |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>on State rem.</b>                                  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)  |  | Date   |
|  | 21. Signature of Funeral Service Licensee<br><b>Ronald S. Wade, Dir.</b>  |  | 22. Name and Address of Facility<br><b>State Anatomy Board-655 W. Baltimore Street<br/>Rm. B026-Baltimore, Maryland 21201-1559</b>                    |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |  |  |
| Physician<br>/Medical<br>Examiner  | Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Chronic Renal Failure</b><br>Due to (or as a consequence of):  |  |   |  |  |
|  | b. Due to (or as a consequence of):   |  |   |  |  |
|  | c. Due to (or as a consequence of):   |  |   |  |  |
|  | d. Due to (or as a consequence of):   |  |   |  |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |   |  |  |
|  | 24a. Was an autopsy performed?<br><b>Partial</b><br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |  |  |
|  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |  |  |
|  | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |  |  |
|  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined                     |  |   |  |  |
| 28a. Date of Injury (Month, Day, Year)   |   |  |   |  |  |
| 28b. Time of Injury<br>M   |   |  |   |  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |   |  |  |
| 28d. Describe how injury occurred  |   |  |   |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |  |   |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |   |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |   |  |  |
| 29b. Signature and title of certifier<br><b>[Signature]</b>  |   | 29c. License number<br><b>O.C.M.E.</b>                                     |   | 29d. Date signed (Month, Day, Year)<br><b>JANUARY 31, 1996</b> |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>David R Fowler 111 Penn Street, Baltimore, Maryland 21201</b>   |   |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 22 1996</b>  |   | 32. Registrar's Signature<br><b>[Signature]</b>                            |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 96 04585

|  |  |  |   |  |   |   |   |   |  |  |
|--|--|--|---|--|---|---|---|---|--|--|
| <b>Physician<br/>/Medical<br/>Examiner</b>   | 1. Decedent's Name (First, Middle, Last)<br><div style="text-align: center; font-size: 1.2em;">Joseph H. Pyles Jr.</div>               |  |   |  |   | 2. Date of Death<br>Month Day Year<br><div style="text-align: center;">February 16 1996</div> |   | 3. Time of Death<br><div style="text-align: center;">6:20 P.M.</div>                                    |  |  |
|  | 4a. Facility Name (If not Institution, give street and number)<br><div style="text-align: center;">3900 S. Hanover Street Apt. 1</div> |  |   |  |   | 4b. City, Town, or Location of Death<br><div style="text-align: center;">Baltimore</div>      |   | 4c. County of Death<br><div style="text-align: center;">N/A</div>                                       |  |  |
| <b>Funeral<br/>Director</b>  | 5. Social Security Number<br><div style="text-align: center;">219 26 7311</div>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><div style="text-align: center;">57 Yrs.</div>  |   | 8. Date of Birth (Month, Day, Year)<br><div style="text-align: center;">Oct. 20, 1938</div>       |   | 9. Birthplace (State or Foreign Country)<br><div style="text-align: center;">Maryland</div>    |  |
|  | Usual Residence of Decedent  |  |   |  |   |   |   |   |  |  |
| 10a. State<br><div style="text-align: center;">Maryland</div>  |  |  | 10b. County<br><div style="text-align: center;">N/A</div>   |  | 10c. City, Town or Location<br><div style="text-align: center;">Baltimore</div>   |   |   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 10e. Street and Number<br><div style="text-align: center;">3900 S. Hanover Street Apt. 1</div>   |  |  |   |  | 10f. Zip Code<br><div style="text-align: center;">21225</div>   |   | 10g. Citizen of What Country?<br><div style="text-align: center;">U.S.</div>                      |   |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <div style="text-align: center;">White</div> |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <div style="text-align: center;">11th</div> College (1-4or 5+) <div style="text-align: center;">College</div>   |  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><div style="text-align: center;">Master Mechanic</div>   |   |   | 16b. Kind of Business/Industry<br><div style="text-align: center;">Construction</div>                   |  |  |
| 17. Father's Name (First, Middle, Last)<br><div style="text-align: center;">Joseph H. Pyles Sr.</div>  |  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><div style="text-align: center;">Hilda Sewell</div>  |   |   |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><div style="text-align: center;">Geraldine Pyles</div>   |  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><div style="text-align: center;">3900 S. Hanover Street Apt.1 Baltimore, Md. 21225</div>   |   |   |   |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><div style="text-align: center;">Cedar Hill Cemetery</div>              |  | Date<br><div style="text-align: center;">2/20/96</div>  |   | 20c. Location - City or Town, State<br><div style="text-align: center;">Baltimore, Maryland</div> |   |  |  |
| 21. Signature of Funeral Service Licensee<br>  |  |  |   |  | 22. Name and Address of Facility<br><div style="text-align: center;">Gonce Funeral Home P.A.<br/>4001 Ritchie Highway Baltimore, Md. 21225</div>  |   |   |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> </div> <div style="width: 60%;"> <p>a. <u>Respiratory Failure</u><br/>Due to (or as a consequence of):</p> <p>b. <u>Persistent / recurrent head and neck cancer</u><br/>Due to (or as a consequence of):</p> <p>c. _____<br/>Due to (or as a consequence of):</p> <p>d. _____<br/>Due to (or as a consequence of):</p> </div> </div> |  |  |   |  |   |   |   |   |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><div style="text-align: center;">1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown</div>  |  |  |   |  |   |   |   |   |  |  |
| 24a. Was an autopsy performed?<br><div style="text-align: center;">1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</div>   |  |  |   |  |   |   |   |   |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><div style="text-align: center;">1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</div>   |  |  |   |  |   |   |   |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |   |  |   |   |   |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   |  | 28. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of injury<br><div style="text-align: center;">M</div>   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                  |   | 28d. Describe how injury occurred  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |   |  |   |   |   |   |  |  |
| 29b. Signature and title of certifier<br>  |  |  |   |  | 29c. License number<br><div style="text-align: center;">D47509</div>  |   | 29d. Date signed (Month, Day, Year)<br><div style="text-align: center;">2 / 20 / 96</div>         |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><div style="text-align: center;">Shelly J McQuone, MD John Hopkins Hosp</div>  |  |  |   |  |   |   |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><div style="text-align: center;">FEB 22 1996</div>  |  |  |   |  | 32. Registrar's Signature<br>   |   |   |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

to the Hospital or Attending Physician: The law requires that the death certificate be executed within 72 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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ITEM: 1. PER F.H. FILM G-732 2/22/96 t.t

FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04586

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <b>BRIDGET MARIE PREISINGER</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>February</b> DAY <b>20</b> YEAR <b>1996</b>  |  | 3. TIME OF DEATH<br><b>6:58 P M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>220-72-9426</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>31</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>January 28, 1965</b>                    |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Good Samaritan Hospital</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>                              |  |
| 9c. COUNTY OF DEATH<br><b>-NA-</b>   |  |  |  | 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>-NA-</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>3103 Hillcrest Avenue</b>                               |  |
| 10f. ZIP CODE<br><b>21234</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>              |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b><br><b>11</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Waitress</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Restaurant</b>   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Leo Cerino</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Margaret VanDaniker</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Margaret Cerino</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3103 Hillcrest Avenue Balto. Maryland 21234</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Parkwood Cemetery February 23, 1996</b>  |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, Maryland</b>   |  | 20d. DATE<br><b>February 23, 1996</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Mark T. Zavovna</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  |  |  |   |  |  |  |
| a. <b>Staphylococcus Aureus Bacteremia</b><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |  |
| b. <b>pneumothorax</b><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |  |
| c. _____<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |  |
| d. _____<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |   |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |   |  |  |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>  |  |  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Ali Moussa, M.D.</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>P09301</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>February 20, 1996</b>                      |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>ALI MOUSSA Good Samaritan Hospital 5601 Loch Raven Blvd Baltimore, MD 21239</b>  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 22 1996</b>  |  |  |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

6-11-88



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 96 04587

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Max Robinson

2. Date of Death

February 20, 1996

3. Time of Death

7:25 am

4a. Facility Name (If not institution, give street and number)

Long Green Nursing Home

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

213-26-5665

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

95

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Aug. 10, 1900

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

6602 Marrott Drive

10f. Zip Code

21207

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married  
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Assistant Supervisor

16b. Kind of Business/Industry

US Postal Service

17. Father's Name (First, Middle, Last)

Abraham Robinson

18. Mother's Name (First, Middle, Maiden Surname)

Agnes Decker

19a. Informant's Name/Relationship (Type, Print)

Sharon Robinson (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1402 Mid Meadow Road Towson MD 21286

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Beth Tfiloh Cem.

Date

Feb. 21, 1996

20c. Location - City or Town, State

Woodlawn MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SOL LEVINSON & BROS., INC.

6010 REISTERSTOWN ROAD BALTIMORE, MD 21215

23a. Part I: Enter the disease or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Dehydration  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Malnutrition  
Due to (or as a consequence of):

c. Dementia  
Due to (or as a consequence of):

d. ASCVD

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?  
☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D28987

29d. Date signed (Month, Day, Year)

2-20-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CARL SPERLING, M.D. 5601 LOCH RAVEN BLVD BALD. MD. 21239

31. Date filed (Month, Day, Year)

FEB 22 1996

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR   |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 96 04588  |  |
|--|--|---|--|--|--|---|--|
|  |  | CERTIFICATE OF DEATH  |  |  |  | REG. NO.  |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Anne Schoolman</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>02</b> DAY <b>10</b> YEAR <b>96</b>   |  | 3. TIME OF DEATH<br><b>550 P.M.</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>359-1018-40</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 6. AGE (In yrs. last birthday)<br><b>94</b> YRS. | IF UNDER 1 YEAR<br>MONTHS <b>01</b> DAYS <b>09</b>   | IF UNDER 24 HRS.<br>HOURS <b>02</b> MIN. <b>00</b> | 7. DATE OF BIRTH (Month, Day, Year)<br><b>01-09-02</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>LORIE NURSING CENTER</b>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>COLUMBIA</b>   |  | 9c. COUNTY OF DEATH<br><b>HOWARD</b>  |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Howard</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Columbia</b>   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO       |  |
| 10e. STREET AND NUMBER<br><b>6334 Cedar Lane</b>   |  |   |  | 10f. ZIP CODE<br><b>21044</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATE <b>UNKNOWN</b> |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                                   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>unknown</b><br>College (14 or 5+) <b>unknown</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>unknown</b>                     |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>unknown</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>unknown</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>unknown</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print) (nephew)<br><b>Dr. Harold Schoolman</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2735 McKinley St. N.W. - Washington, D.C. 20015</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)   |  | DATE   |  | 20c. LOCATION — City or Town, State   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Ronald S. Wade, Dir.</b>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>State Anatomy Board-655 W. Baltimore Street<br/>Rm. B026-Baltimore, Maryland 21201-1559</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |  |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  | a. <b>Dehydration</b><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |
|  |  | b. <b>Cerebrovascular Accident</b><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |
|  |  | c. <b>Hypertension</b><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |
|  |  | d.  |  |  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M <b>1</b>  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                      |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  | 29c. LICENSE NUMBER<br><b>025876</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>2/14/96</b>   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Richard W. Smith M.D.</b>  |  |   |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Richard W. Smith, M.D. 10802 Hickory Ridge Rd. Columbia 21044</b>  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 22 1996</b>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><b>John Anderson</b>  |  |   |  |

88-100

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04589

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

GERTRUDE SHANKLIN

2. Date of Death  
Month Day Year  
FEBRUARY-21-19963. Time of Death  
10:10AM

4a. Facility Name (If not institution, give street and number)

Harbor Hospital Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

219 28 9050

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Sept. 14, 1907

9. Birthplace (State or Foreign Country)

Germany

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7 Third Avenue

10f. Zip Code

21225

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (14 or 5+)

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Home Maker

16b. Kind of Business/Industry

In own home

17. Father's Name (First, Middle, Last)

Gottlieb Fischer

18. Mother's Name (First, Middle, Maiden Surname)

Wilhelmina Seybold

19a. Informant's Name/Relationship (Type, Print)

Albert Roesler

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10 Third Avenue Baltimore, Maryland 21225

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory, Inc.

Date

2/22/96

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Gonce Funeral Home P.A.  
4001 Ritchie Highway Baltimore, Md. 21225

23a. Part I. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CANDIDIAL SEPTICEMIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

10 DAYS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

BILATERAL PLEURAL EFFUSION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M.D.

29c. License number

AS 2441614-36

29d. Date signed (Month, Day, Year)

FEBRUARY-21-1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TARIQ MIRZA, 7115 RD, ROLLING BEND ROAD, BALTIMORE, MD 21244

31. Date filed (Month, Day, Year)

FEB 22 1996

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 48 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed and filed in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

2000-01-01

1. The first part of the report is a general introduction to the project. It describes the objectives of the study and the scope of the work. The second part of the report is a detailed description of the methodology used in the study. This includes a description of the data sources, the data collection methods, and the data analysis methods. The third part of the report is a description of the results of the study. This includes a description of the data, the results of the data analysis, and the conclusions drawn from the study. The fourth part of the report is a discussion of the results of the study. This includes a discussion of the strengths and weaknesses of the study, a discussion of the implications of the results, and a discussion of the future research needs.

2. The first part of the report is a general introduction to the project. It describes the objectives of the study and the scope of the work. The second part of the report is a detailed description of the methodology used in the study. This includes a description of the data sources, the data collection methods, and the data analysis methods. The third part of the report is a description of the results of the study. This includes a description of the data, the results of the data analysis, and the conclusions drawn from the study. The fourth part of the report is a discussion of the results of the study. This includes a discussion of the strengths and weaknesses of the study, a discussion of the implications of the results, and a discussion of the future research needs.

3. The first part of the report is a general introduction to the project. It describes the objectives of the study and the scope of the work. The second part of the report is a detailed description of the methodology used in the study. This includes a description of the data sources, the data collection methods, and the data analysis methods. The third part of the report is a description of the results of the study. This includes a description of the data, the results of the data analysis, and the conclusions drawn from the study. The fourth part of the report is a discussion of the results of the study. This includes a discussion of the strengths and weaknesses of the study, a discussion of the implications of the results, and a discussion of the future research needs.

4. The first part of the report is a general introduction to the project. It describes the objectives of the study and the scope of the work. The second part of the report is a detailed description of the methodology used in the study. This includes a description of the data sources, the data collection methods, and the data analysis methods. The third part of the report is a description of the results of the study. This includes a description of the data, the results of the data analysis, and the conclusions drawn from the study. The fourth part of the report is a discussion of the results of the study. This includes a discussion of the strengths and weaknesses of the study, a discussion of the implications of the results, and a discussion of the future research needs.



TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04590

|  |  |  |  |  |  |   |  |   |  |  |  |
|--|--|--|--|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Richard L. Shannon</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>Feb</b> DAY <b>16</b> YEAR <b>96</b>  |  | 3. TIME OF DEATH<br><b>1600 M</b>                                 |  |   |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>220 58 1453</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>39</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Mar 24 56</b>           |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>   |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>North Arundel Hosp</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Glen Burnie</b>  |  |   |  | 9c. COUNTY OF DEATH<br><b>AA</b>  |  |  |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Anne Arundel</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>  |  |   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO       |  |  |  |
| 10e. STREET AND NUMBER<br><b>301 Camrose Avenue</b>  |  |  |  | 10f. ZIP CODE<br><b>21225</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                    |  |   |  |  |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                               |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4 years</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Accountant</b>           |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Accounting Firm</b>   |  |   |  |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Paul W. Shannon</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mary C. Burns</b>  |  |   |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Patricia Heil</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>755 Gaither Road Sykesville, Maryland 21784</b>  |  |   |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Voshell Cemetery</b>                                   |  | DATE<br><b>2/21</b>  |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, Maryland</b> |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Richard Gonce</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>George J. Gonce Funeral Home P.A.<br/>4001 Ritchie Hwy. Baltimore, Md. 21225</b>  |  |   |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Asphyxia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. Hanging</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |  |  |  |  |   |  | Approximate Interval Between Onset and Death  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |  |   |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |  |  |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>2/16/96</b>   |  | 28b. TIME OF INJURY<br><b>AM</b>                                  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO           |  | 28d. DESCRIBE HOW INJURY OCCURRED<br><b>Hung Self.</b>   |  |
|  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>Home</b>  |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>Baltimore, MD.</b> |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |   |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>William P. Jones MD Deputy</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D06054</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>2/17/96</b>             |  |   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>William P. Jones, MD 695 America 21035</b>   |  |  |  |  |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 22 1996</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |   |  |   |  |  |  |

006: 3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 96 04591  
3. Time of Death 1:30pm

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Essie Simpson

2. Date of Death  
Month 2 Day 20 Year 96

4b. City, Town, or Location of Death

Baltimore, MD

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

226-30-9212

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

69

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

June 17, 1926

9. Birthplace (State or Foreign Country)

La

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3813 Bartwood Road

10f. Zip Code

21215

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8th grade

College (1-4 or 5+)

NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Veterinary Assistant

16b. Kind of Business/Industry

Hospital

17. Father's Name (First, Middle, Last)

James Simpson

18. Mother's Name (First, Middle, Maiden Surname)

Bertha Brown

19a. Informant's Name/Relationship (Type, Print)

Kathy L. Brown Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3813 Bartwood Road Balto, MD 21215

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

Date

2/21/96

20c. Location - City or Town, State

Catonsville, MD

21. Signature of Funeral Service Licensee

Quinn D. Brown

22. Name and Address of Facility

March F. H. West  
4300 Wabash Avenue Balto, MD 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Probable lung cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

NIDDM

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☒ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician

2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Robert Johnson, MD

29c. License number

D42638

29d. Date signed (Month, Day, Year)

2/21/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert Johnson MD Suite 22 Hoffberger Bldg

2435 W. Belvedere Avenue Baltimore, MD 21215

31. Date filed (Month, Day, Year)

FEB 22 1996

32. Registrar's Signature

Julia Simpson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

103



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04592

|  |  |  |  |  |  |  |  |   |  |  |  |   |  |
|--|--|--|--|--|--|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Rdcl Spears</i>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><i>02 01 1996</i>  |  |  |  | 3. TIME OF DEATH<br><i>0820 A M</i>   |  |  |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><i>405-07-2074</i>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 8. AGE (In yrs. last birthday)<br><i>88</i> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>August 8 1907</i> |  | 8. BIRTHPLACE (State or Foreign Country)<br><i>Kentucky</i> |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>Shady Grove Adventist Hospital</i>  |  |  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Rockville</i>  |  |   |  | 9c. COUNTY OF DEATH<br><i>Montgomery</i>                       |  |   |  |
| RESIDENCE OF DECEDENT  |  |  |  |  |  |  |  |   |  |  |  |   |  |
| 10a. STATE<br><i>Maryland</i>  |  | 10b. COUNTY<br><i>Montgomery</i>   |  | 10c. CITY, TOWN OR LOCATION<br><i>Rockville</i>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |  |  |   |  |
| 10e. STREET AND NUMBER<br><i>90 Monroe St #201</i>   |  |  |  |  |  | 10f. ZIP CODE<br><i>20850</i>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |  |  |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>WHITE</i>                         |  |  |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><i>Elementary/Secondary (8-12)</i><br><i>8</i>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>Homemaker</i>  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>At Home</i>  |  |  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Norwood Gibson</i>   |  |  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Nannie Hunley</i>  |  |   |  |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Lois Hoff</i>   |  |  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>13605 Valley Drive Rockville, MD 20850</i> |  |   |  |  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Ivy Hill Cemetery</i>  |  |  |  | DATE<br><i>2/5/96</i>   |  | 20c. LOCATION — City or Town, State<br><i>Alex. VA</i>         |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>John C. Eversley</i>   |  |  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>Everly-Wheatley Funeral Home<br/>1500 W Braddock Rd. Alex. VA</i>                                       |  |   |  |  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Bilateral Pneumonia</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><i>Stroke</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><i>Atherosclerosis</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Approximate interval Between Onset and Death<br><i>Five days</i><br><i>Two weeks</i><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |  |  |  |  |   |  |  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Parkinson's Disease Syndrome</i><br><i>Atrial Fibrillation</i>  |  |  |  |  |  |  |  |   |  |  |  |   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |  |  |  |  |  |   |  |  |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |  |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide  |  |  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br><i>M</i>  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  | 28d. DESCRIBE NOW INJURY OCCURRED                              |  |   |  |
|  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                    |  |  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |  |  |   |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Christopher C. Dunford</i>   |  |  |  |  |  | 29c. LICENSE NUMBER<br><i>031839</i>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>February 1, 1996</i>                                  |  |  |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>Christopher C. Dunford, M.D., Rockville, MD 20850</i>  |  |  |  |  |  |  |  |   |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><i>FEB 22 1996</i>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John C. Eversley</i>   |  |  |  |   |  |  |  |   |  |



10. THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04593

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>EUGENE SHEPPARD</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Feb 15 1996</b>  |  | 3. TIME OF DEATH<br><b>1:47 pm</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>213-32-1950</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>61</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Dec. 17, 1934</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Saint Joseph Medical Center</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Towson, Maryland</b>   |  |
| 9c. COUNTY OF DEATH<br><b>Baltimore</b>   |  |  |  | 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Baltimore</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>6931A Donachie Road</b>   |  |
| 10f. ZIP CODE<br><b>21239</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12</b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Supervisor</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Steel</b>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Frank Sheppard</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Ida Pawlowski</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mrs. Anita M. Sheppard</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6931A Donachie Rd., Baltimore, Md. 21239</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Sacred Heart of Jesus Cem. 2-19</b>   |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, Md.</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Ann S. Matthews</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Matthews Funeral Home<br/>3021 Eastern Ave., Baltimore, Md. 21224</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b><br><b>a. MASSIVE HEART ATTACK WITH CARDIOGENIC SHOCK</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. Coronary artery bypass surgery with biventricular assist</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c. device insertion</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d.</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  | Approximate Interval Between Onset and Death<br><b>2 DAYS</b>  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>  |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 29a. CERTIFIER<br>(Check only)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Garth McDonald, M.D. Chief Resident Surgery</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D 26151</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>2-15-96</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>GARTH McDONALD, M.D. 7620 YORK ROAD TOWSON, MARYLAND 21204</b>  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>Feb 22 1996</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>John A. H. ...</b>  |  |  |  |

Page 10

1. The first part of the report is a summary of the work done during the last year.

2. The second part is a detailed account of the experiments carried out.

3. The third part is a discussion of the results obtained.

4. The fourth part is a conclusion of the work.

5. The fifth part is a list of references.

6. The sixth part is a list of acknowledgments.

7. The seventh part is a list of appendices.

8. The eighth part is a list of figures.

9. The ninth part is a list of tables.

10. The tenth part is a list of footnotes.

11. The eleventh part is a list of errata.

12. The twelfth part is a list of corrections.

13. The thirteenth part is a list of additions.

14. The fourteenth part is a list of deletions.

15. The fifteenth part is a list of changes.



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 96 04594

|  |   |  |   |                                |  |
|--|---|--|---|--------------------------------|--|
| <b>Physician<br/>/Medical<br/>Examiner</b>   | 1. Decedent's Name (First, Middle, Last)<br><b>OSCAR SISSELMAN</b>  |  | 2. Date of Death<br>Month <b>FEBRUARY</b> Day <b>19</b> , Year <b>1996</b>  |                                | 3. Time of Death<br><b>2:24 P.M</b>  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>5200 PARK HEIGHTS AVE</b>  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>  |                                | 4c. County of Death<br><b>N/A</b>  |
| <b>Funeral<br/>Director</b>  | 5. Social Security Number<br><b>217-12-8490</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>71</b> Yrs.  | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   |
|  | 8. Date of Birth<br>Month, Day, Year<br><b>Sept 6, 1924</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |                                |  |
| <b>To Be Completed by Funeral Director</b>   | Usual Residence of Decedent   |  |   |                                |  |
|  | 10a. State<br><b>Maryland</b>   | 10b. County<br><b>Baltimore</b>  | 10c. City, Town or Location<br><b>Owings Mills</b>  |                                | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |
|  | 10e. Street and Number<br><b>5626 Triplett Road</b>   |  | 10f. Zip Code<br><b>21117</b>   |                                | 10g. Citizen of What Country?<br><b>USA</b>  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WWII</b> |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|  | 14. Race - American Indian, Black, White, etc.<br><b>White</b>  |  | Specify:  |                                |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6</b> College (1-4or 5+)  |  | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Salesman</b>                                  |                                | 16b. Kind of Business/Industry<br><b>Candy And Tobacco</b>   |
|  | 17. Father's Name (First, Middle, Last)<br><b>Morris Sisselman</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Rose Ginsberg</b>   |                                |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Faye Sisselman (wife)</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5626 Triplett RD Owings Mills MD 21117</b>                |                                |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Adath Yeshurn Cem</b>  |                                | Date<br><b>Feb 21, 1996</b>  |
|  | 20c. Location - City or Town, State<br><b>Baltimore MD</b>  |  | 21. Signature of Funeral Service Licensee<br>   |                                |  |
| 22. Name and Address of Facility<br><b>SOL LEVINSON &amp; BROS., INC.<br/>6010 REISTERSTOWN ROAD BALTIMORE, MD 21215</b> |   |  |   |                                |  |
| <b>Physician<br/>/Medical<br/>Examiner</b>   | 23a. Part I. Enter the disease or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Atherosclerotic Cardiovascular Disease</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |   |                                |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |   |                                |  |
|  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |                                |  |
|  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |                                |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |                                |  |
|  | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |                                |  |
|  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>RACE TRACK</b>   |  |   |                                |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |                                |  |
|  | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |                                |  |
|  | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |                                |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |   |                                |  |
| <b>Medical Certification: To Be Completed by Physician/Medical Examiner</b>  | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |                                |  |
|  | 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>O.C.M.E.</b>  |                                | 29d. Date signed (Month, Day, Year)<br><b>FEBRUARY 20, 1996</b>  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>HAROLD R. D. KOBEN JR 111 Penn Street, Baltimore, Maryland 21201</b>   |  |   |                                |  |
|  | 31. Date filed (Month, Day, Year)<br><b>FEB 22 1996</b>   |  |   |                                |  |
| 32. Registrar's Signature<br>  |   |  |   |                                |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

102,10 22



102,10 22

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04595

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ALBERT E. SANDERSON, JR

2. Date of Death  
Month Day Year  
FEBRUARY 21, 1996

3. Time of Death

6:24 a.m.

4a. Facility Name (If not institution, give street and number)

NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death

GLEN BURNIE

4c. County of Death

ANNE ARUNDEL

Funeral  
Director5. Social Security Number  
579-20-73816. Sex  
☒ M ☐ F7. Age (In yrs. last birthday)  
72 Yrs.If Under 1 Year  
Months DaysIf Under 24 Hrs.  
Hours Min.8. Date of Birth  
Month Day Year  
JULY 6, 19239. Birthplace (State or Foreign  
Country)  
Maryland

Usual Residence of Decedent

10a. State  
Maryland10b. County  
Anne Arundel10c. City, Town or Location  
Crownsville

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

346 S. Riverside Drive

10f. Zip Code

21032

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: WWII13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Biologist

16b. Kind of Business/Industry  
State of Maryland/  
Natural Resources

17. Father's Name (First, Middle, Last)

Albert Edward Sanderson

18. Mother's Name (First, Middle, Maiden Surname)

Caroline Louise Tallman

19a. Informant's Name/Relationship (Type, Print)

Loralea Lynn Sanderson/Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5451 Columbia Rd., Apt. 225 Columbia, MD 21044

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metro Crematory, Inc. 02/22/96

Date

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Dawn F. McDonald

22. Name and Address of Facility

Cremation Society of Maryland, Inc.  
299 Frederick Rd. Baltimore, MD 2122823a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

Cardiac arrest

Approximate  
Interval Between  
Onset and Death

1 day

e. Due to (or as a consequence of):

Recent myocardial infarction

2 weeks

b. Due to (or as a consequence of):

status post coronary Bypass

10+ yr

c. Due to (or as a consequence of):

Parkinsonism

5 yr

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ NoHospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D14136

29d. Date signed (Month, Day, Year)

2/21/96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

DALJIT S. SAWHNEY, M.D. 1600 CRAIN HIGHWAY, SW, GLEN BURNIE, MARYLAND 21061

31. Date filed (Month, Day, Year)

FEB 22 1996

32. Registrar's Signature

Juli Anderson

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

to the hospital or attending physician: The law requires that the death certificate be executed  
within 72 hours after death.  
The Funeral Director: After this certificate has been signed by the attending physician and  
community filed in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within \_\_\_\_\_ hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04596

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

|   |  |   |  |   |  |  |  |   |  |   |  |
|---|--|---|--|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>James Morton Smith, Jr.</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>February</b> DAY <b>4</b> YEAR <b>1996</b>   |  | 3. TIME OF DEATH<br><b>10:00 P M</b>   |  |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>213-70-0744</b>   |  | 5. SEX<br><b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>38</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>10-6-58</b>   |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Baltimore</b>  |  |   |  |
| 9. FACILITY NAME (If not institution, give street and number)<br><b>Maryland General Hospital</b>   |  |   |  | 9a. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore City</b>  |  |  | 9c. COUNTY OF DEATH<br><b>Baltimore City</b>                           |   |  |   |  |
| 10a. STATE<br><b>Maryland</b>   |  |   |  | 10b. COUNTY<br><b>NA</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore City</b>   |  | 10d. INSIDE CITY LIMITS?<br><b>1</b> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                |  |   |  |
| 10e. STREET AND NUMBER<br><b>1144 N. Stricker Street</b>  |  |   |  | 10f. ZIP CODE<br><b>21217</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A</b>  |  |   |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>YES, GIVE WAR OR DATES<br><b>National Guards</b>  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify: |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify <b>Black</b> |   |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary School (0-12) <b>12th</b> College (1-4 or 5+) <b>Cobbler</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Cobbler</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>N/A</b>  |  |  |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>James Morton Smith</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Evelyn Pearl Smith</b>  |  |  |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Pamela Smith</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>N/A</b>   |  |  |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>MT. ZION CEMETERY April Baltimore, Maryland</b>   |  | 20c. LOCATION — City or Town, State   |  |  |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Irvin P. Carroll</b>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>IRVIN P. CARROLL FUNERAL HOME<br/>1712 W. NORTH AVE, BALTO. MD 21217</b>   |  |  |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>sepsis</b><br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>Hypothermia</b><br><b>Cryptococcal meningitis</b><br><b>Advanced AIDS</b> |  |   |  |   |  |  |  | Approximate Interval Between Onset and Death  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>poly substance abuse</b>   |  |   |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |   |  |   |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <b>1</b> <input checked="" type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA OTHER: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify) |  |   |  |  |  |   |  |   |  |
| 27. MANNER OF DEATH<br><b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation<br><b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined<br><b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
|   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                       |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><b>1</b> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Colleen Denise Jude, M.D.</b>   |  |   |  | 29c. LICENSE NUMBER<br><b>D28544</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>02/04/96</b>  |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 22) (Type, Print)<br><b>Colleen D. Jude 1001 Cathedral St. Baltimore, MD 21201</b>  |  |   |  |   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 22 1996</b>   |  | 32. REGISTRAR'S SIGNATURE<br><b>Jude Davidson-Randall</b>   |  |   |  |  |  |   |  |   |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 96 04597

|   |  |  |   |  |  |  |   |  |  |  |  |  |  |  |
|---|--|--|---|--|--|--|---|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedant's Name (First, Middle, Last)<br><b>Leon Tilles</b>   |  |   |  | 2. Date of Death<br>Month <b>February</b> Day <b>18</b> Year <b>1996</b>   |  |   |  | 3. Time of Death<br><b>10:30 pm</b>  |  |  |  |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Montgomery General Hospital</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Olney</b>   |  |   |  | 4c. County of Death<br><b>Montgomery</b>   |  |  |  |  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>216-32-7850</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>87</b> Yrs.   |  | If Under 1 Year<br>Months Days  |  | If Under 24 Hrs.<br>Hours Min.   |  | 8. Date of Birth (Month, Day, Year)<br><b>March 24, 1908</b> |  | 9. Birthplace (State or Foreign Country)<br><b>Lithuania</b> |  |
|   | Usual Residence of Decedant  |  |   |  |  |  |   |  |  |  |  |  |  |  |
| To Be Completed by Funeral Director           | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Montgomery</b>  |  | 10c. City, Town or Location<br><b>Silver Spring</b>  |  |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |  |  |  |
|   | 10e. Street and Number<br><b>14514 Homecrest Road</b>  |  |   |  | 10f. Zip Code<br><b>20906</b>  |  |   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |  |  |  |
|   | 11. Marital Status<br><input checked="" type="checkbox"/> Navar Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |  |  |  |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> Collage (1-4or 5+) <b></b>  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Proprietor</b>   |  |   |  | 16b. Kind of Business/Industry<br><b>Food Market</b>   |  |  |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Kopel Tilles</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Sumama)<br><b>Jenny Stokliski</b>   |  |   |  |  |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br><b>William Tilles (son)</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>12040 Montrose Village Terrace Rockville MD 20852</b>                                    |  |   |  |  |  |  |  |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Workmen Circle Cem.</b>   |  |   |  | Data<br><b>Feb. 20, 1996</b>   |  | 20c. Location - City or Town, State<br><b>Dundalk MD</b>     |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>SOL LEVINSON &amp; BROS., INC.<br/>6010 REISTERSTOWN ROAD BALTIMORE, MD 21215</b>   |  |   |  |  |  |  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or organ failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. CARDIAC ARRHYTHMIA</b><br>Due to (or as a consequence of):<br><b>b. CORONARY ARTERY DISEASE</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>Diabetes mellitus</b><br><b>congestive heart failure</b> |  |   |  |  |  |   |  |  |  |  |  |  |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |  |  |  |   |  |  |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |  |   |  |  |  |  |  |  |  |
|   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |  |   |  |  |  |  |  |  |  |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |  |   |  |  |  |  |  |  |  |
|   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |   |  |  |  |   |  |  |  |  |  |  |  |
|   | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  |   |  |  |  |   |  |  |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 28a. Date of injury (Month, Day Year)  |  |   |  | 28b. Time of injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |  |  |  |  |
|   | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |  |  |  |  |  |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |  |  |   |  |  |  |  |  |  |  |
|   | 29b. Signature and title of certifier<br>  |  |   |  | 29c. License number<br><b>P38457</b>   |  |   |  | 29d. Date signed (Month, Day, Year)<br><b>FEBRUARY 19, 1996</b>                                |  |  |  |  |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>N. GOYAL MD, 1811 Prince Philip Dr, Olney MD 20832</b>  |  |   |  |  |  |   |  |  |  |  |  |  |  |
| State<br>Registrar                            | 31. Date filed (Month, Day, Year)<br><b>FEB 22 1996</b>  |  |   |  |  |  |   |  |  |  |  |  |  |  |
|   | 32. Registrar's Signature<br>  |  |   |  |  |  |   |  |  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR   |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 96 04598  |  |  |  |
|--|--|--|--|--|--|---|--|---|--|--|--|
| CERTIFICATE OF DEATH   |  |  |  | REG. NO.   |  |   |  |   |  |  |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br>GENEVA NETTIE TOBEY  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>FEB. 15, 1996  |  |   |  | 3. TIME OF DEATH<br>12:07 PM  |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br>577-09-6723   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>84 YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>March 15, 1911                                 |  | 8. BIRTHPLACE (State or Foreign Country)<br>New Jersey  |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Washington Adventist Hospital  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Takoma Park   |  |   |  | 9c. COUNTY OF DEATH<br>Montgomery   |  |  |  |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Montgomery  |  | 10c. CITY, TOWN OR LOCATION<br>Silver Spring   |  |   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |  |  |
| 10e. STREET AND NUMBER<br>1131 University Blvd., West, Apt. #719   |  |  |  | 10f. ZIP CODE<br>20902   |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                             |  |  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 Yrs<br>College (1-4 or 5+) College (1-4 or 5+)   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Cost Accountant  |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Accounting  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Louis Katz  |  |  |  | 16. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Rebecca Rifkin  |  |   |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>S. Alexander Tobey   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1131 University Boulevard, West, Apartment #719<br>Silver Spring, Maryland 20902  |  |   |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Mount Lebanon Cemetery  |  | DATE<br>2/19/1996  |  | 20c. LOCATION — City or Town, State<br>Adelphi, Maryland                              |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Donald C. Stottmeyer  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>STEIN HEBREW MEMORIAL FUNERAL HOME, INC.<br>232 CARROLL STREET, N.W.<br>WASHINGTON, D.C. 20012-2095  |  |   |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → Brain Death<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF): Cardiac Arrhythmia<br>b. DUE TO (OR AS A CONSEQUENCE OF): Coronary Artery Disease<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Approximate Interval Between Onset and Death<br>5 days<br>5 days<br>7 years |  |  |  |  |  |   |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>  |  |  |  |  |  |   |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 28. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO            |  |  |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                    |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |   |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>James L. Cockrell, Jr., M.D.  |  |  |  | 29c. LICENSE NUMBER<br>D44571  |  |   |  | 29d. DATE SIGNED (Month, Day, Year)<br>2/15/96  |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>James L. Cockrell, Jr., M.D.<br>17600 Carroll Ave - Takoma Park, MD 20912   |  |  |  |  |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>FEB 22 1996   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>John Anderson   |  |   |  |   |  |  |  |


30240 25

James C. Thompson

96 04599

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Gwen R. Thompson   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>Feb. 21 1996   |  | 3. TIME OF DEATH<br>3:42 A M   |  |
| 4. SOCIAL SECURITY NUMBER<br>550-48-8338   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>65 92 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>Oct. 15, 1930   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Colorado   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>Lorien Nursing Home  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Columbia  |  |
| 9c. COUNTY OF DEATH<br>Howard  |  |  |  | 10a. STATE<br>MD   |  | 10b. COUNTY<br>Howard  |  |
| 10c. CITY, TOWN OR LOCATION<br>Columbia  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br>6334 Cedar Lane  |  |
| 10f. ZIP CODE<br>21044   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 10 College (14 or 5+) None  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Receptionist   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Dental Office  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Alexander Ross  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Carolyn E. Bain   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Carol Simonet (Daughter)   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4879 Campbell Ave. Apt. #8, San Jose, CA 95130  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Metro Crematory Feb. 21, 1996   |  | 20c. LOCATION — City or Town, State<br>Catonsville, MD   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Leroy & Russell Witzke Funeral Home<br>5555 Twin Knolls Rd. Columbia, MD 21045   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Alzheimer's Disease</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE NOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>William Flowers MD  |  |  |  | 29c. LICENSE NUMBER<br>D20789  |  | 29d. DATE SIGNED (Month, Day, Year)<br>Feb 21, 1996  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>11055 Little Patuxent Columbia md 21044   |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>FEB 22 1996   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>Julia Bruckner Randall  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

20200000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04600

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

THEODORE I. TURNER SR.

2. Date of Death

Month 2/15/96 Day Year

3. Time of Death

21:00 hrs

4a. Facility Name (If not institution, give street and number)

(HOME) 3916 WABASH AVE, APT, 2B

4b. City, Town, or Location of Death

BALTO.

4c. County of Death

BALTO. CITY

Funeral  
Director

5. Social Security Number

218 07 8178

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

82

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month 7/11/13 Day Year

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD.

10b. County

BALTO. CITY

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

3916 WABASH AVE, APT.2B

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: W.W. 2

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

PORTER (RETIRED)

16b. Kind of Business/Industry

HUTZLER, S CO.

17. Father's Name (First, Middle, Last)

ISAIH N. TURNER

18. Mother's Name (First, Middle, Maiden Surname)

ROSIE R. TURNER

19a. Informant's Name/Relationship (Type, Print)

DOROTHY JACKSON SISTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1507 CLAIRIDGE RD. BALTO. MD. 21207

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BALTO. NATIONAL 2/21/96

Date

20c. Location - City or Town, State

BALTO. MD.

21. Signature of Funeral Service Licensee

Kamal K. Dang

22. Name and Address of Facility

ESTEP BROTHERS FUNERAL HOME P.A.  
1300 EUTAW PL. BALTO. MD. 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. High grade metastatic prostate Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 yr. ±

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Severe chronic obstructive lung disease.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 8 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Kamal K. Dang MD

29c. License number

D18362

29d. Date signed (Month, Day, Year)

2/19/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KOMAL K. DANG M.D., 700, Washington Boulevard, Balto., MD

31. Date filed (Month, Day, Year)

FEB 22 1996

32. Registrar's Signature

John H. H. H. H.

21230

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

10027 21

1. The first part of the report deals with the general situation of the country and the progress of the work during the year. It is a summary of the work done by the various departments and a statement of the results achieved. It is a general statement of the work done and is not a detailed report of the work of any one department.

2. The second part of the report deals with the work of the various departments. It is a detailed report of the work of each department and is a statement of the results achieved. It is a detailed report of the work of each department and is a statement of the results achieved.

3. The third part of the report deals with the work of the various departments. It is a detailed report of the work of each department and is a statement of the results achieved. It is a detailed report of the work of each department and is a statement of the results achieved.

4. The fourth part of the report deals with the work of the various departments. It is a detailed report of the work of each department and is a statement of the results achieved. It is a detailed report of the work of each department and is a statement of the results achieved.

5. The fifth part of the report deals with the work of the various departments. It is a detailed report of the work of each department and is a statement of the results achieved. It is a detailed report of the work of each department and is a statement of the results achieved.

1. The first part of the report deals with the general situation of the country and the progress of the work during the year. It is a summary of the work done by the various departments and a statement of the results achieved. It is a general statement of the work done and is not a detailed report of the work of any one department.

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4. The fourth part of the report deals with the work of the various departments. It is a detailed report of the work of each department and is a statement of the results achieved. It is a detailed report of the work of each department and is a statement of the results achieved.

5. The fifth part of the report deals with the work of the various departments. It is a detailed report of the work of each department and is a statement of the results achieved. It is a detailed report of the work of each department and is a statement of the results achieved.

1. THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| FOR STATE REGISTRAR  |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 96 04601   |  |
|--|--|--|--|---|--|--|--|--|--|
| 1. DECEASED'S NAME (First, Middle, Last)   |  |  |  | 2. DATE OF DEATH  |  |  |  | 3. TIME OF DEATH   |  |
| RONALD TIRES   |  |  |  | 2-13-1996   |  |  |  | 6:15 A.M.  |  |
| 4. SOCIAL SECURITY NUMBER  |  | 5. SEX   |  | 6. AGE (In yrs. last birthday)  |  | 7. DATE OF BIRTH                               |  | 8. BIRTHPLACE (State or Foreign Country)                                     |  |
| 217-54-4160  |  | 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                 |  | 45 YRS.   |  | 1/17/1951                                      |  | MD   |  |
| 9a. FACILITY NAME (If not institution, give street and number)   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH   |  |  |  | 9c. COUNTY OF DEATH  |  |
| JOSEPH RICHIE HOSPICE  |  |  |  | BALTIMORE   |  |  |  | BALTO. CITY  |  |
| RESIDENCE OF DECEASED  |  |  |  |   |  |  |  |  |  |
| 10a. STATE   |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION   |  |  |  | 10d. INSIDE CITY LIMITS?   |  |
| MD   |  | BALTO. CITY  |  | BALTIMORE   |  |  |  | 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO      |  |
| 10e. STREET AND NUMBER   |  |  |  | 10f. ZIP CODE   |  | 10g. CITIZEN OF WHAT COUNTRY?                  |  |  |  |
| 355-s DALLAS CT.   |  |  |  | 21231   |  | U.S.A.   |  |  |  |
| 11. MARITAL STATUS   |  | 12. WAS DECEASED EVER IN U.S. ARMED FORCES?  |  | 13. WAS DECEASED OF HISPANIC ORIGIN?  |  | 14. RACE — American Indian, Black, White, etc. |  | Specify: BLACK   |  |
| 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>Specify:   |  |  |  |  |  |
| 15. DECEASED'S EDUCATION (Specify only highest grade completed)  |  |  |  | 16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |
| Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0   |  |  |  | HANDYMAN  |  |  |  | UNKNOWN  |  |
| 17. FATHER'S NAME (First, Middle, Last)  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)   |  |  |  |  |  |
| JAMES TIRES  |  |  |  | DOROTHY DAVIS   |  |  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)   |  |  |  |  |  |
| CHARLES TIRES  |  |  |  | 219 CANDY TUFT RD REISTERSTOWN MD 21136   |  |  |  |  |  |
| 20a. METHOD OF DISPOSITION   |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of institution, cemetery or other place)   |  |  |  | 20c. LOCATION — City or Town, State  |  |
| 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | WESTERN STAR CEM. 2/17/1996   |  |  |  | CATONVILLE MD  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  |  |  |  | 22. NAME AND ADDRESS OF FACILITY  |  |  |  |  |  |
|   |  |  |  | ESTEP BROTHERS FUNERAL HOME P.A.<br>1300 EUTAW PLACE BALTIMORE MD 21217   |  |  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |  |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  |  |  | LARGE CELL LYMPHOMA   |  |  |  | Approximate interval Between Onset and Death<br>20 MONTHS                    |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  |  |  | a. DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |
|  |  |  |  | b. DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |
|  |  |  |  | c. DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |
|  |  |  |  | d. DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?   |  |  |  |  |  |
| 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |  |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |  |   |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?   |  |  |  | 26. PLACE OF DEATH (Check only one)   |  |  |  |  |  |
| 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) HOSPICE |  |  |  |  |  |
| 27. MANNER OF DEATH  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY                            |  | 28c. INJURY AT WORK?   |  |
| 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |  |  |  |   |  | M  |  | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                 |  |
|  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  |  |  |
|  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |  |
|  |  |  |  |   |  |  |  |  |  |
| 29a. CERTIFIER (Check only)  |  |  |  |   |  |  |  |  |  |
| 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |  |  |  |
| 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  |  |  |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)            |  |  |  |
|  M.D.   |  |  |  | D06933  |  | FEB 13 1996                                    |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  |  |  |  |   |  |  |  |  |  |
| JOHN B. MACGIBBON MD 101 W READ ST. BALTIMORE MD 21201   |  |  |  |   |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)  |  |  |  | 32. REGISTRATION  |  |  |  |  |  |
| FEB 22 1996  |  |  |  |    |  |  |  |  |  |

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04602

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Hugh Joseph Townsend Jr.

2. Date of Death

Month  
FebDay  
19Year  
1996

3. Time of Death

9:00 PM

4a. Facility Name (If not Institution, give street and number)

2502 Gray Manor Terrace

4b. City, Town, or Location of Death

N/A

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

234-50-3001

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

60

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
Dec 21, 1935

9. Birthplace (State or Foreign Country)

W. Virginia

Usual Residence of Decedent

10a. State

Md

10b. County

Baltimore

10c. City, Town or Location

N/A

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

2502 Gray Manor Terrace

10f. Zip Code

21222

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No

If Yes, Give Year or Dates:

1952

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Ironworker

16b. Kind of Business/Industry

Concrete

17. Father's Name (First, Middle, Last)

Hugh J. Townsend

18. Mother's Name (First, Middle, Maiden Surname)

Ines M. Pritchard

19a. Informant's Name/Relationship (Type, Print)

Anna M. Townsend / wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2502 Gray Manor Terrace Baltimore, Md 21222

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

Date

2/22/96

20c. Location - City or Town, State

Catonsville, Md

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Connelly Funeral Home of Dundalk

7110 Sollers Point Rd 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Lung Cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 Months

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Metastasis to Bone

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D09264

29d. Date signed (Month, Day, Year)

2/20/96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Amable Mendoza, M.D. VA Medical Center Fort Howard, Md 21052

31. Date filed (Month, Day, Year)

FEB 22 1996

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The few requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

2028



## Certificate of Death

Reg. No. 96 04603

|   |   |  |  |  |  |  |  |  |  |  |
|---|---|--|--|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>DONALD VAUGHN</b>                              |  |  |  | 2. Date of Death<br>Month Day Year<br><b>JAN. 27, 1996</b> |  | 3. Time of Death<br><b>2:26 PM</b>   |  |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>1407 N. CAROLINE ST.</b> |  |  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |  | 4c. County of Death<br><b>n/a</b>  |  |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>unknown</b>   |  | 8. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>unknown</b> Yrs.  | If Under 1 Year<br>Months Days                             | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth<br>(Month, Day, Year)<br><b>unknown</b>                                       | 9. Birthplace (State or Foreign Country)<br><b>unknown</b>   |  |  |
|   | Usual Residence of Decedent   |  |  |  |  |  |  |  |  |  |
| 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>n/a</b>  |  | 10c. City, Town or Location<br><b>Baltimore</b>  |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |  |
| 10e. Street and Number<br><b>1407 N. Caroline Street</b>  |   |  |  | 10f. Zip Code<br><b>21213</b>  |  | 10g. Citizen of What Country?<br><b>unknown</b>  |  |  |  |  |
| 11. Marital Status<br><b>unknown</b><br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>unknown</b><br><input type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  |  |  |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>unknown</b> College (1-4 or 5+) <b>unknown</b>   |   |  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>unknown</b>   |  | 16b. Kind of Business/Industry<br><b>unknown</b>   |  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>unknown</b>   |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>unknown</b>  |  |  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>unknown</b>  |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>unknown</b>  |  |  |  |  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>State interment</b>  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)   |  | Date   |  | 20c. Location - City or Town, State  |  |  |  |  |
| 21. Signature of Funeral Service Licensee<br>   |   |  |  | 22. Name and Address of Facility<br><b>Ronald S. Wade, Dir. State Anatomy Board-655 W. Baltimore Street Rm. B026-Baltimore, Maryland 21201-1559</b>  |  |  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Arteriosclerotic cardiovascular disease</b><br>Due to (or as a consequence of):<br><br>b. _____ Due to (or as a consequence of):<br><br>c. _____ Due to (or as a consequence of):<br><br>d. _____<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |  |  |  |  |  |  |  | Approximate Interval Between Onset and Death |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |  |  |  |
|   |   |  |  |  |  | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |  |  |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of injury (Month, Day Year)  |  | 28b. Time of injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28d. Describe how injury occurred  |  |  |
|   |   | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner   |   | 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |  |  |  |  |  |  |
| 29b. Signature and title of certifier<br><b>Donald G. Wright MD</b>   |   |  |  | 29c. License number<br><b>O.C.M.E.</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>JAN. 28, 1996</b>  |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DONALD G. WRIGHT MD 111 Penn Street, Baltimore, Maryland 21201</b>   |   |  |  |  |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 22 1996</b>   |   | 32. Registrar's Signature<br>   |  |  |  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

207.46

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ITEM: 31. PER FIELD REP.  
FILM G-732 2/22/96 t.t

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 96 04604

Item, Film 733, 3/4/96, 1t

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Shailesh Vora

2. Date of Death

February 19 1996

3. Time of Death

3:22 PM

4a. Facility Name (If not institution, give street and number)

Sinai Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

217-98-4678

6. Sex

Male ☒ Female ☐

7. Age (In yrs. last birthday)

41

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

JAN 27, 1955

9. Birthplace (State or Foreign Country)

India

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Cockeysville

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

1203 Walnut Wood Road

10f. Zip Code

21030

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Asian Indian

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

President/Owner Vice President

16b. Kind of Business/Industry

Transportation Company

17. Father's Name (First, Middle, Last)

Mugatlal Vora

18. Mother's Name (First, Middle, Maiden Surname)

Ansuyaben Varia

19a. Informant's Name/Relationship (Type, Print)

Kiran Vora/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1203 Walnut Wood Rd. Cockeysville, MD 21030

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory, Inc. 2/20/96

Date

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Dawn F. McDonald

22. Name and Address of Facility

Cremation Society of Maryland, Inc.  
299 Frederick Rd. Baltimore, MD 21228

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Multiple Organ System Failure

Due to (or as a consequence of):

b. Poorly Differentiated Adenocarcinoma

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient

☐ ER/Outpatient

☐ DOA

Other:

☐ Nursing Home

☐ Residence

☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Joel Pearlman MD PhD

29c. License number

AS2402321 JP9952

29d. Date signed (Month, Day, Year)

February 19, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joel Pearlman MD PhD 2401 W. Belvedere Ave. Baltimore, MD 21215

31. Date filed (Month, Day, Year)

February 19, 1996

32. Registrar's Signature

FEB 22 1996 Julia Brundage Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.  
State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

Reg. No. 96 04605

|  |   |   |  |  |   |  |  |   |  |
|--|---|---|--|--|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>GRACE I. WHITELEY                         |   |  |  | 2. Date of Death<br>Month Day Year<br>FEBRUARY 18, 1996 |  | 3. Time of Death<br>10:15 P.M.   |   |  |
|  | 4e. Facility Name (If not institution, give street and number)<br>UNIVERSITY HOSPITAL |   |  |  | 4b. City, Town, or Location of Death<br>BALTIMORE       |  | 4c. County of Death<br>Baltimore City  |   |  |
| Funeral<br>Director  | 5. Social Security Number<br>173-07-2927  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>81 Yrs.  | If Under 1 Year<br>Months Days                          | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>Feb. 10, 1915   | 9. Birthplace (State or Foreign Country)<br>Pennsylvania  |  |
|  | Usual Residence of Decedent   |   |  |  |   |  |  |   |  |
| 10a. State<br>MD   |   | 10b. County<br>Carroll County   |  | 10c. City, Town or Location<br>Sykesville  |   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   |  |
| 10e. Street and Number<br>6608 Sweet Air Lane  |   |   |  | 10f. Zip Code<br>21784   |   | 10g. Citizen of What Country?<br>U.S.A.  |  |   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4or 5+)   |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker   |   | 16b. Kind of Business/Industry<br>Domestic   |  |   |  |
| 17. Father's Name (First, Middle, Last)<br>John R. Getty   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Irene Strouse   |   |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Mrs. Jerilyn M. Martin (Daughter)  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>6608 Sweet Air Lane Sykesville, MD 21784  |   |  |  |   |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Greenmount Cemetery   |  | Date<br>2/24/96  |   | 20c. Location - City or Town, State<br>West Chester, PA  |  |   |  |
| 21. Signature of Funeral Service Licensee<br>Brian D. Haight   |   |   |  | 22. Name and Address of Facility<br>HAIGHT FUNERAL HOME (P.O. box 195)<br>Sykesville, MD 21784 (410)-795-1400  |   |  |  |   |  |
| 23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. Multiple Injuries<br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |   |   |  |  |   |  |  | Approximate Interval Between Onset and Death  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |   |  |
|  |   |   |  |  |   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |   |  |  |   |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day Year)<br>2-18-96  |  | 28b. Time of Injury<br>1720 M  |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred<br>passenger Auto - Auto collision  |  |
|  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>Roadway   |  |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>Liberty Rd & Rt 26   |  |   |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   | 29b. Signature and title of certifier<br>David R Fowler   |  | 29c. License number<br>O.C.M.E.  |   | 29d. Date signed (Month, Day, Year)<br>FEBRUARY 19, 1996   |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>David R Fowler 111 Penn Street, Baltimore, Maryland 21201  |   |   |  |  |   |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br>FEB 22 1996   |   |   | 32. Registrar's Signature<br>John Davidson-Randall                             |  |   |  |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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3002-00



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04606

|   |   |   |  |  |  |  |   |  |
|---|---|---|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>GERALD WILKINS  |   |  |  | 2. Date of Death<br>Month Day Year<br>FEBRUARY 13, 1996  |  | 3. Time of Death<br>7:35 PM   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Prince George's Hospital Center   |   |  |  | 4b. City, Town, or Location of Death<br>Cheverly   |  | 4c. County of Death<br>Prince George's  |  |
| Funeral<br>Director   | 5. Social Security Number<br>222-24-5113  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>53 Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>April 20, 1942  |   | 9. Birthplace (State or Foreign Country)<br>Delaware   |
|   | Usual Residence of Decedent   |   |  |  |  |  |   |  |
| To Be Completed by Funeral Director   | 10a. State<br>Maryland  | 10b. County<br>Prince George's  | 10c. City, Town or Location<br>Hyattsville   |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   |  |
|   | 10e. Street and Number<br>6500 Riggs Road   |   |  | 10f. Zip Code<br>20783   |  | 10g. Citizen of What Country?<br>U.S.A.  |   |  |
|   | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) unknown<br>College (1-4 or 5+) unknown   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>unknown                       |  | 16b. Kind of Business/Industry<br>unknown  |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br>unknown  |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>unknown Viola Smith   |  |   |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br>Helen Perry   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>unknown                   |  |  |   |  |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation - 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>An State rem.  |  | Date   |  | 20c. Location - City or Town, State   |  |
|   | 21. Signature of Funeral Service Licensee<br>Ronald S. Wade   |   |  | 22. Name and Address of Facility<br>State Anatomy Board-655 W. Baltimore Street<br>Rm. B026-Baltimore, Maryland 21201-1559 |  |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Cardiopulmonary arrest<br>Due to (or as a consequence of):<br>b. Sepsis<br>Due to (or as a consequence of):<br>c. Disseminated mycobacterium kansasii<br>Due to (or as a consequence of):<br>d. AIDS |   |  |  |  |  |   | Approximate Interval Between Onset and Death<br>a. one day<br>b. one day<br>c. one month<br>d. 2 yrs.  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |  |  |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |   |  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No               |   | 28d. Describe how injury occurred  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br>[Signature]  |  | 29c. License number<br>D46093  |  | 29d. Date signed (Month, Day, Year)<br>2/16/96   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Rodman Mustaghim 7305 Hanover Parkway, Greenbelt MD, 20770  |   |   |  |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br>FEB 22 1996  |   | 32. Registrar's Signature<br>[Signature]  |  |  |  |  |   |  |

30222 20

[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]

96-803-031  
96-031  
jhm

ITEM: 3. PER MED FILM G-734  
4/18/96 t.t

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.  
State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

Reg. No. 96 04607

|   |   |  |   |  |  |                                      |  |  |  |  |  |
|---|---|--|---|--|--|--------------------------------------|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>MICHAEL WOODSON                             |  |   |  | 2. Date of Death<br>Month Day Year<br>FEBRUARY 16 1996   |                                      | 3. Time of Death<br>2:40 PM  |  |  |  |  |
|   | 4a. Facility Name (If not Institution, give street and number)<br>1900 LYTONSVILLE ROAD |  |   |  | 4b. City, Town, or Location of Death<br>SILVER SPRING  |                                      | 4c. County of Death<br>MONTGOMERY  |  |  |  |  |
| Funeral<br>Director   | 5. Social Security Number<br>210-58-6587  |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>17 Yrs.  |                                      | 8. Date of Birth (Month, Day, Year)<br>NOV 23 1977   |  | 9. Birthplace (State or Foreign Country)<br>PA   |  |  |
|   | Usual Residence of Decedent   |  |   |  |  |                                      |  |  |  |  |  |
| 10a. State<br>PA  |   |  | 10b. County<br>N/A  |  |  | 10c. City, Town or Location<br>PHILA |  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |
| 10e. Street and Number<br>6056 ALLMAN STREET  |   |  |   | 10f. Zip Code<br>19143   |  |                                      | 10g. Citizen of What Country?<br>U.S.A.  |  |  |  |  |
| 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   |  | 12. Was Decedent Ever In U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                      |  | 14. Race - American Indian, Black, White, etc.<br>Specify: BLACK   |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 10TH<br>College (1-4 or 5+) N/A  |   |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>STUDENT |  |                                      | 16b. Kind of Business/Industry<br>JOB CORP   |  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br>ANTHONY DICKINSON  |   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>VERONICA RUCKER   |                                      |  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>VERONICA WOODSON Mother   |   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>6056 ALLMAN STREET PHILA, PA 19143  |                                      |  |  |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>FERNWOOD CEMETERY   |  | Date<br>3/2/96   |                                      | 20c. Location - City or Town, State<br>FERNWOOD, PA  |  |  |  |  |
| 21. Signature of Funeral Service Licensee<br><i>John March</i>  |   |  |   |  | 22. Name and Address of Facility<br>MARCH F/H-WEST 4300 WABASH AVE   |                                      |  |  |  |  |  |
| 23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <i>Multiple injuries, generalized body burns</i><br>Due to (or as a consequence of):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |   |  |   |  |  |                                      |  |  |  | Approximate Interval Between Onset and Death |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |  |   |  |  |                                      | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |  |  |
|   |   |  |   |  |  |                                      | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input checked="" type="checkbox"/> Other (Specify) SCENE |  |  |                                      |  |  |  |  |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |   |  | 28a. Date of Injury (Month, Day, Year)<br>2-16-96   |  | 28b. Time of Injury<br>1740 M  |                                      | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred<br>Occupant Train collision  |  |  |
|   |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>Railroad  |  |  |                                      |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>Silver Spring, Montgomery Co |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |  | 29b. Signature and title of certifier<br><i>Donald G. Wright MD</i>   |  |  | 29c. License number<br>O.C.M.E.      |  | 29d. Date signed (Month, Day, Year)<br>FEBRUARY 17 1996  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>DONALD G. WRIGHT MD 111 Penn Street, Baltimore, Maryland 21201  |   |  |   |  |  |                                      |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>FEB 22 1996  |   |  | 32. Registrar's Signature<br><i>Julia Davidson-Randall</i>  |  |  |                                      |  |  |  |  |  |

Baltimore, Maryland 21215-0020  
Permit. Page 1 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director  
To Be Completed by Physician/Medical Examiner

106:17 8/2

106:17 8/2

106:17 8/2

106:17 8/2

106:17 8/2

106:17 8/2

106:17 8/2

106:17 8/2

106:17 8/2

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04608

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Dorothy Wheeler

2. Date of Death

February 20, 1996

3. Time of Death

2:45 A

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Maryland General Hospital

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

109-03-3816

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

AUG. 31, 1912

9. Birthplace (State or Foreign Country)

NEW YORK

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ANNE ARUNDEL

10c. City, Town or Location

MILLERSVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8366 WOODLAND ROAD

10f. Zip Code

21108

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

ANTON BARTEL

18. Mother's Name (First, Middle, Maiden Summa)

ANNIE STONE

19a. Informant's Name/Relationship (Type, Print)

CHARLES F. WHEELER/SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8366 WOODLAND RD. MILLERSVILLE, MD 21108

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

HOLLY HILLS CEM. FEB. 22, 1996

Data

20c. Location - City or Town, State

MIDDLE RIVER, MD

21. Signature of Funeral Service Licensee

Cori L. Ebaugh

22. Name and Address of Facility

KIRKLEY-RUDDICK FUNERAL HOME

421 CRAIN HWY. S.E. GLEN BURNIE, MD 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Severe Aortic Stenosis

Due to (or as a consequence of):

Pneumonia

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

N. Kolongo

29c. License number

39247

29d. Date signed (Month, Day, Year)

February 20, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nsekenene Kolongo, M.D. c/o Maryland General Hospital

31. Date filed (Month, Day, Year)

FEB 22 1996

32. Registrar's Signature

John A. ...

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

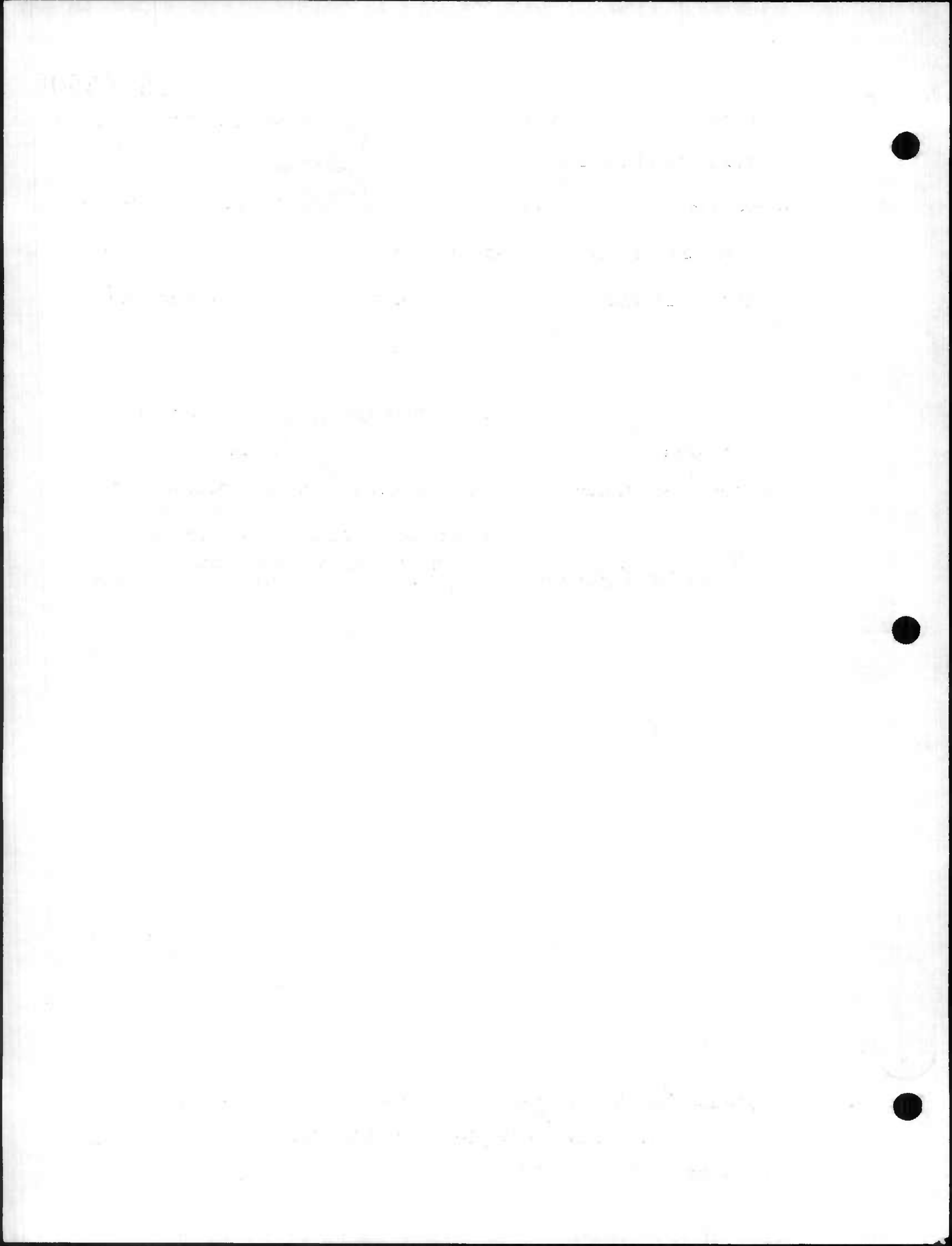
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



VOID

CERTIFICATE 88

96-04609

SEE

CERTIFICATE 88

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR  |  |   |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 96 046110   |  |  |  |   |  |  |  |
|---|--|---|--|--|--|--|--|---|--|--|--|---|--|--|--|
| CERTIFICATE OF DEATH  |  |   |  | REG. NO.   |  |  |  |   |  |  |  |   |  |  |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Richard A. Williams</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>Feb</b> DAY <b>19</b> YEAR <b>1996</b>  |  |  |  | 3. TIME OF DEATH<br><b>9 35 A M</b>   |  |  |  |   |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>214-12-4540</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>75</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS <b>09</b> DAYS <b>17</b> |  | IF UNDER 24 HRS.<br>HOURS <b>17</b> MIN. <b>21</b>  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>09-17-1921</b> |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>MARYLAND</b>   |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Baltimore V.A. Hospital</b>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>  |  |  |  | 9c. COUNTY OF DEATH<br><b>BALTIMORE CITY</b>  |  |  |  |   |  |  |  |
| 10a. STATE<br><b>MARYLAND</b>   |  | 10b. COUNTY<br><b>BALTIMORE, CITY</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |  |  |   |  |  |  |
| 10e. STREET AND NUMBER<br><b>1100 PENNSYLVANIA AVENUE APT. 1101</b>   |  |   |  | 10f. ZIP CODE<br><b>21201</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  |  |   |  |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>                         |  |  |  |   |  |  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>   |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>TRUCK DRIVER</b>  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>HANLINE PAINT COMPANY</b>                                  |  |  |  |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>RICHARD WILLIAMS</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>ELIZABETH WILSON</b>   |  |  |  |   |  |  |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>BERTINA WILLIAMS (WIFE)</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1100 PENNSYLVANIA AVE. APT. 1101 BALTO. MD. 21201</b>  |  |  |  |   |  |  |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>GARRISON FOREST CEMETERY 2/23/96</b>   |  |  |  | 20c. LOCATION — City or Town, State<br><b>OWINGSMILLS, MARYLAND</b>                             |  |  |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>ESTEP BROTHERS FUNERAL HOME PA.<br/>1300 EUTAW PLACE BALTIMORE, MARYLAND 21217</b>  |  |  |  |   |  |  |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. uncal herniation</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. Cerebral Vascular infarct</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c. hypertension</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d.</b> |  |   |  |  |  |  |  |   |  |  |  | Approximate interval Between Onset and Death<br><b>3 days</b><br><b>one week</b><br><b>20 years</b>   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/></b>  |  |   |  |  |  |  |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |  |  |   |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide   |  |   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>                    |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  | 28d. DESCRIBE HOW INJURY OCCURRED                        |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Rachel Hinerman M.D.</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>P08668</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>2/19/96</b>    |  |   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Rachel Hinerman 10 N. Greene St Baltimore MD 21201</b>  |  |   |  |  |  |  |  |   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 22 1996</b>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>Johanna [Signature]</i>  |  |  |  |   |  |  |  |   |  |  |  |

01270 II

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR   |  |   |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   | REG. NO. 96 04611  |  |  |  |
|---|--|---|--|---|--|--|---|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MARIAN ALICE WALLACE</b>   |  |   |  |   |  | 2. DATE OF DEATH<br>MONTH <b>January</b> DAY <b>15</b> YEAR <b>1996</b>          |   | 3. TIME OF DEATH<br><b>9:10 p. M</b>   |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>215-58-1451</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 6. AGE (In yrs. last birthday)<br><b>45</b> YRS. | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>  | IF UNDER 24 HRS.<br>HOURS <b></b> MIN. <b></b> | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Oct. 28, 1950</b>                   |   | 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>                                |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>677 Ragan Road</b>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Conowingo</b>   |  | 9c. COUNTY OF DEATH<br><b>Cecil</b>  |   |  |  |  |  |
| RESIDENCE OF DECEDENT   |  |   |  |   |  |  |   |  |  |  |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Cecil</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Conowingo</b>   |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |  |  |  |
| 10e. STREET AND NUMBER<br><b>677 Ragan Road</b>   |  |   |  | 10f. ZIP CODE<br><b>21918</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                   |   |  |  |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                         |  |  |  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th grade</b> College (1-4 or 5+) <b>4</b>   |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Home</b>                                    |   |  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Homer Earl Wallace</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Ruth Irene Scarborough</b>  |  |  |   |  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print) (friend)<br><b>Robert Shires</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>677 Ragan Road-Conowingo, Maryland 21918</b>  |  |  |   |  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)   |  | DATE  |  | 20c. LOCATION — City or Town, State  |   |  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Ronald S. Wade, Dir.</i>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>State Anatomy Board-655 W. Baltimore Street<br/>Rm.B026-Baltimore, Maryland 21201-1559</b>   |  |  |   |  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Cancer of the neck, unknown primary</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Diseases or injury that initiated events resulting in death) LAST { b.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Approximate Interval Between Onset and Death<br><b>1 year</b> |  |   |  |   |  |  |   |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |   |  |   |  |  |   |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |   |  |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |   | 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |  |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |  |   |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Wayne M. Koch</i>   |  |   |  | 29c. LICENSE NUMBER<br><b>D35051</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>2/12/96</b>                            |   |  |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>WAYNE M. KOCH, MD P.O. Box 41402 BALTIMORE, MD 21203-6402</b>   |  |   |  |   |  |  |   |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 22 1996</b>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>John H. ...</i>   |  |  |   |  |  |  |  |

11210

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 96 04612

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) **Leona Cook Wetzel** 2. Date of Death Month Day Year **Feb. 16, 1996** 3. Time of Death **6:15 AM**

4a. Facility Name (If not Institution, give street and number) **Golden Age Guest Home** 4b. City, Town, or Location of Death **Sykesville** 4c. County of Death **Carroll**

Funeral  
Director

5. Social Security Number **217 28 5674** 6. Sex ☐ M ☒ F 7. Age (In yrs. last birthday) Yrs. **96** 8. Date of Birth (Month, Day, Year) **Sept 20, 1899** 9. Birthplace (State or Foreign Country) **Md.**

Usual Residence of Decedent 10a. State **Md.** 10b. County **Carroll** 10c. City, Town or Location **Westminster** 10d. Inside City Limits ☐ Yes ☒ No

10e. Street and Number **620 Oak Tree Road** 10f. Zip Code **21157** 10g. Citizen of What Country? **U.S.A.**

11. Marital Status ☐ Never Married ☐ Married ☒ Widowed ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? ☐ Yes ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes ☒ No Specify: 14. Race - American Indian, Black, White, etc. Specify: **White**

15. Decedent's Education (Specify only highest grade completed) **Elementary/Secondary (0-12) 7** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) **Merchant** 16b. Kind of Business/Industry **Store and Garage**

17. Father's Name (First, Middle, Last) **George Wilson Cook** 18. Mother's Name (First, Middle, Maiden Surname) **Celeste Pearl Gist**

19a. Informant's Name/Relationship (Type, Print) **Thomas Eugene Will** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **620 Oak Tree Road Westminster, Md. 21157**

20a. Method of Disposition ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) **Lake View Mem. Park** 20c. Location - City or Town, State **Sykesville, Md.**

21. Signature of Funeral Service Licensee **Harry W. Haight** 22. Name and Address of Facility **Haight Funeral Home P.O. Box 195 Sykesville, Md. 21784**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Pulmonary Degenerative Disease** Approximate Interval Between Onset and Death **5 yrs**

Immediate Cause (Final disease or condition resulting in death) **Pulmonary Degenerative Disease** Due to (or as a consequence of): **Pulmonary Degenerative Disease** Due to (or as a consequence of): **Pulmonary Degenerative Disease** Due to (or as a consequence of): **Pulmonary Degenerative Disease** Due to (or as a consequence of): **Pulmonary Degenerative Disease**

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? ☐ Yes ☒ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed? ☐ Yes ☒ No 24b. Were autopsy findings available prior to completion of cause of death? ☐ Yes ☒ No

25. Was case referred to medical examiner? ☐ Yes ☒ No 26. Place of Death (Check only one) Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death ☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be determined 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? ☐ Yes ☒ No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier **Patrick A. Turney, MD** 29c. License number **D20806** 29d. Date signed (Month, Day, Year) **2/19/96**

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) **Patrick A. Turney, MD 1425 Liberty Rd Eldersburg, MD 21789**

31. Date filed (Month, Day, Year) **FEB 22 1996** 32. Registrar's Signature **Patricia A. Turney**

State  
Registrar

Baltimore, Maryland 21215-0020

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 04613  
February 19, 1996 6:45 P.M.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Elizabeth Wiest

2. Date of Death

Month Day Year  
February 19, 1996

3. Time of Death

6:45 P.M.

4a. Facility Name (If not institution, give street and number)

Edenwald

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore County

5. Social Security Number

216-01-5592

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Nov. 18, 1912

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore County

10c. City, Town or Location

Towson

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

800 Southerly Road

10f. Zip Code

21286

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th Grade

Collage (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Executive Secretary

16b. Kind of Business/Industry

Paper Company

17. Father's Name (First, Middle, Last)

Louis Unknown Bender

18. Mother's Name (First, Middle, Maiden Surname)

Alvina Unknown Muller

19a. Informant's Name/Relationship (Type, Print)

Henry NMN Schmalbach / Cousin

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

401-C Lake Vista Circle, Cockeysville, Maryland 21030

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hilltop Service Corporation

20c. Location - City or Town, State

Towson, Maryland

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

John C. Miller, Inc.  
6415 Belair Road, Baltimore, Maryland 21206

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

Stroke

Approximate Interval Between Onset and Death

2 wks

b. Due to (or as a consequence of):

Dehydration

1 wk.

c. Due to (or as a consequence of):

Arteriosclerotic disease

5 yrs

d. Due to (or as a consequence of):

Hypertension

5 yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*[Signature]* Physician

29c. License number

D 29 761

29d. Date signed (Month, Day, Year)

2/21/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Maria Lino D. Alvarado

516 N. Rolling Rd Bn 1A 21228

31. Date filed (Month, Day, Year)

FEB 22 1996

32. Registrar's Signature

*[Signature]*

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

1017

[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 96 04614

|   |   |  |   |  |   |  |   |  |  |  |   |    |                |  |    |                         |    |                            |    |
|---|---|--|---|--|---|--|---|--|--|--|---|----|----------------|--|----|-------------------------|----|----------------------------|----|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Elizabeth Louise Appell /aka/ Louise G. Appell  |  |   |  | 2. Date of Death<br>Month Day Year<br>February 20, 1996   |  |   |  | 3. Time of Death<br>3:00 AM  |  |   |    |                |  |    |                         |    |                            |    |
|   | 4a. Facility Name (If not institution, give street and number)<br>Greater Baltimore Medical Center  |  |   |  | 4b. City, Town, or Location of Death<br>Baltimore   |  |   |  | 4c. County of Death<br>Baltimore   |  |   |    |                |  |    |                         |    |                            |    |
| Funeral<br>Director   | 5. Social Security Number<br>214-30-4863  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>61 Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br>Aug. 1, 1934 |  | 9. Birthplace (State or Foreign Country)<br>Maryland   |  |   |    |                |  |    |                         |    |                            |    |
|   | Usual Residence of Decedent   |  |   |  |   |  |   |  |  |  |   |    |                |  |    |                         |    |                            |    |
| To Be Completed by Funeral Director   | 10a. State<br>Maryland  |  | 10b. County<br>Baltimore  |  | 10c. City, Town or Location<br>Baltimore  |  |   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |   |    |                |  |    |                         |    |                            |    |
|   | 10e. Street and Number<br>1337 Dalton Road  |  |   |  | 10f. Zip Code<br>21234  |  | 10g. Citizen of What Country?<br>U.S.A.             |  |  |  |   |    |                |  |    |                         |    |                            |    |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |  |   |    |                |  |    |                         |    |                            |    |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+) 1 year   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Bookkeeper   |  |   | 16b. Kind of Business/Industry<br>Real Estate Company            |  |  |   |    |                |  |    |                         |    |                            |    |
|   | 17. Father's Name (First, Middle, Last)<br>Peter Grau   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Elva Smith   |  |   |  |  |  |   |    |                |  |    |                         |    |                            |    |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Robert Bruce Appell (Son)   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>12 Hillman Court, Aberdeen, Maryland 21001   |  |   |  |  |  |   |    |                |  |    |                         |    |                            |    |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Dulaney Valley Mem. Gardens 2/22  |  | 20c. Location - City or Town, State<br>Timonium, Maryland   |  |   |  |  |  |   |    |                |  |    |                         |    |                            |    |
|   | 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br>Schimunek Funeral Home<br>9705 Belair Road, Baltimore, Maryland 21236   |  |   |  |  |  |   |    |                |  |    |                         |    |                            |    |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.  |  |   |  |   |  |   |  |  |  |   |    |                |  |    |                         |    |                            |    |
|   | <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td>gram(-) Sepsis</td> <td rowspan="4">Approximate Interval Between Onset and Death</td> </tr> <tr> <td>b.</td> <td>pancytopenia post chemo</td> </tr> <tr> <td>c.</td> <td>extensive (L) TONSILAR CA.</td> </tr> <tr> <td>d.</td> <td></td> </tr> </table> |  |   |  |   |  |   |  |  |  | Immediate Cause (Final disease or condition resulting in death) | a. | gram(-) Sepsis | Approximate Interval Between Onset and Death | b. | pancytopenia post chemo | c. | extensive (L) TONSILAR CA. | d. |
| Immediate Cause (Final disease or condition resulting in death)   | a.  | gram(-) Sepsis   | Approximate Interval Between Onset and Death  |  |   |  |   |  |  |  |   |    |                |  |    |                         |    |                            |    |
|   | b.  | pancytopenia post chemo  |   |  |   |  |   |  |  |  |   |    |                |  |    |                         |    |                            |    |
|   | c.  | extensive (L) TONSILAR CA.   |   |  |   |  |   |  |  |  |   |    |                |  |    |                         |    |                            |    |
|   | d.  |  |   |  |   |  |   |  |  |  |   |    |                |  |    |                         |    |                            |    |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>malnutrition  |   |  |   |  |   |  |   |  |  |  |   |    |                |  |    |                         |    |                            |    |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |   |  |   |  |   |  |   |  |  |  |   |    |                |  |    |                         |    |                            |    |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |   |  |   |  |   |  |  |  |   |    |                |  |    |                         |    |                            |    |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |  |   |  |   |  |   |  |  |  |   |    |                |  |    |                         |    |                            |    |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |   |  |   |  |   |  |  |  |   |    |                |  |    |                         |    |                            |    |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |   |  |   |  |   |  |   |  |  |  |   |    |                |  |    |                         |    |                            |    |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |   |  |   |  |   |  |   |  |  |  |   |    |                |  |    |                         |    |                            |    |
| 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   | 28d. Describe how injury occurred              |   |  |  |  |   |    |                |  |    |                         |    |                            |    |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |   |  |   |  |   |  |  |  |   |    |                |  |    |                         |    |                            |    |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |   |  |   |  |   |  |  |  |   |    |                |  |    |                         |    |                            |    |
| 29b. Signature and title of certifier<br>   |   |  |   | 29c. License number<br>D28594  |   | 29d. Date signed (Month, Day, Year)<br>2/20/96 |   |  |  |  |   |    |                |  |    |                         |    |                            |    |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Dr. Ruth Kantor, 6569 N. Charles St., Towson, MD 21204  |   |  |   |  |   |  |   |  |  |  |   |    |                |  |    |                         |    |                            |    |
| 31. Date filed (Month, Day, Year)<br>FEB 23 1996  |   |  |   |  |   |  |   |  |  |  |   |    |                |  |    |                         |    |                            |    |
| 32. Registrar's Signature<br>   |   |  |   |  |   |  |   |  |  |  |   |    |                |  |    |                         |    |                            |    |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



96-843-510  
CIP

ITEMS: 23 PART 1, 27,  
28a-f, PER MEO FILM G-733  
3/6/96 t.t

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 96 04615

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>LARRY</b>  |  | 2. Date of Death<br>Month <b>FEBRUARY</b> Day <b>19</b> Year <b>1996</b>  |  | 3. Time of Death<br><b>12:10PM</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>2617 "A" SHIRLEY AVENUE</b>  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>  |  | 4c. County of Death<br><b>N/a</b>  |  |
| 5. Social Security Number<br><b>212-48-0161</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>46</b> Yrs.   |  |
| 8. Date of Birth (Month, Day, Year)<br><b>02 18 1950</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>   |  |  |  |
| Usual Residence of Decedent   |  | 10e. State<br><b>MD</b>   |  | 10b. County<br><b>N/A</b>  |  |
| 10c. City, Town or Location<br><b>BALTIMORE</b>   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |
| 10e. Street and Number<br><b>2617 SHIRLEY AVENUE</b>  |  | 10f. Zip Code<br><b>21215</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2</b> College (1-4or 5+)  |  | 16. Kind of Business/Industry<br><b>CITY OF BALTIMORE</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>RAYMOND EUGENE AUSTIN</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>DOROTHY BOGGS</b>   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>DOROTHY BYRD MOTHER</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3820 COTTAGE AVENUE, BALTO. MD. 21215</b>   |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>KING MEMORIAL PARK 02-24-96</b>  |  | 20c. Location - City or Town, State<br><b>RANDALLSTOWN, MD.</b>  |  |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>ALBERT P. WYLIE F/H PA<br/>638 N. GILMOR STREET 21217</b>  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>NARCOTIC INTOXICATION</b><br>Due to (or as a consequence of):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Approximate Interval Between Onset and Death |  |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |  |  |  |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |  |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input checked="" type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input checked="" type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)<br><b>FOUND 2/19/96</b>  |  | 28b. Time of Injury<br><b>12:10 A M</b>  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred<br><b>UNKNOWN</b>   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>2617 "A" SHIRLEY AVE. BALTIMORE, MD.</b>  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  |  |
| 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>O.C.M.E.</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>FEBRUARY 20, 1996</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>MARYLAND 11 Penn Street, Baltimore, Maryland 21201</b>   |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 23 1996</b>   |  |   |  |  |  |

State Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04616

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

FRANCES

L.

AMBERG

2. Date of Death

FEB.

Day

22,

Year

1996

3. Time of Death

6:30 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

1 DELMENY CT

# 104

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE

5. Social Security Number

216 12 5910

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

JAN. 21, 1920

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10e. State

MARYLAND

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1 DELMENY CT #104

10f. Zip Code

21234

10g. Citizen of What Country?

UNITE STATES

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

DOMESTIC

17. Father's Name (First, Middle, Last)

DAVID

HOWE

LUCCHESI

18. Mother's Name (First, Middle, Maiden Surname)

LILLIAN

MARIE

MEYERS

19e. Informant's Name/Relationship (Type, Print)

J. MARTIN AMBERG

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

920 W. 38th STREET, BALTIMORE, MD 21211

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

GREEN MOUNT CREMATORY

Date

2/24/96

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

Stephen D. Lohrmann

22. Name and Address of Facility

CAFA STEPHEN D. LOHRMANN P.A.

8717 GREEN PASTURES DR., BALTIMORE, MD 21286

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

e. Metastatic CA of Endometrium

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

M

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Patricia V. Patrício

29c. License number

008358

29d. Date signed (Month, Day, Year)

2/23/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GRACIE V. PATRICIO

31. Date filed (Month, Day, Year)

FEB 23 1996

32. Registrar's Signature

Li. Andrew Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 04617

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

George W. Benson Jr.

2. Date of Death

Month Day Year  
Feb. 12, 1996

3. Time of Death

1:25 PM

4a. Facility Name (If not institution, give street and number)

Hopkins Bayview

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

218-52-4636

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

43

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb. 16, 1952

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

903 Foxridge Lane

10f. Zip Code

21221

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12th grade

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Crane Operator

16b. Kind of Business/Industry

Bethlehem Steel

17. Father's Name (First, Middle, Last)

George W. Benson Sr.

18. Mother's Name (First, Middle, Maiden Summa)

Mary Frances Huber

19a. Informant's Name/Relationship (Type, Print)

George W. Benson III (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

903 Foxridge Lane, Baltimore, Maryland 21221

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Moreland Memorial Park 2/16/96

Date

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Schimunek Funeral Home  
3331 Brehms Lane, Baltimore, Maryland 21213

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Cardiac arrhythmia*

Due to (or as a consequence of):

b. *diffuse severe atherosclerotic disease*

Due to (or as a consequence of):

c. *hypertension*

Due to (or as a consequence of):

d. *coronary artery disease*

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

20 minutes

3 hours

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

1D-26434

29d. Date signed (Month, Day, Year)

2/14/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ARTHUR SCHROEDER MIDDLESEX HEALTH CENTER 1245 EASTERN BLVD BALTO

31. Date filed (Month, Day, Year)

FEB 23 1996

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.  
State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

Reg. No. 96 04618

|   |   |  |   |  |   |  |
|---|---|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>DENTON BOWEN  |  | 2. Date of Death<br>Month Day Year<br>FEB. 10, 1996   |  | 3. Time of Death<br>7:00 PM   |  |
|   | 4e. Facility Name (If not institution, give street and number)<br>311 CATHEDRAL ST.   |  | 4b. City, Town, or Location of Death<br>BALTIMORE   |  | 4c. County of Death<br>N/A  |  |
| Funeral<br>Director                           | 5. Social Security Number<br>UNKNOWN  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>36 Yrs.   |  |
|   | 8. Date of Birth<br>Month Day Year<br>SEPT. 18, 1959  |  | 9. Birthplace (State or Foreign Country)<br>JAMAICA   |  | 10. Usual Residence of Decedent<br>10e. State: N.Y. 10b. County: KINGS 10c. City, Town or Location: BROOKLYN 10d. Inside City Limits: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
| To Be Completed by Funeral Director           | 10e. Street and Number<br>848 CLARKSON AVE.   |  | 10f. Zip Code<br>11203  |  | 10g. Citizen of What Country?<br>JAMAICA  |  |
|   | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:              |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12): 12 College (1-4or 5+):  |  | 18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>SELF EMPLOYED  |  | 16b. Kind of Business/Industry<br>KINGS+QUEEN GROCERY   |  |
|   | 17. Father's Name (First, Middle, Last)<br>EUGENE BOWEN   |  | 16. Mother's Name (First, Middle, Maiden Surname)<br>BERNICE STELLING   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: BLACK  |  |
| To Be Completed by Physician/Medical Examiner | 19e. Informant's Name/Relationship (Type, Print)<br>BERNICE STELLING  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>848 CLARKSON AVE. BROOKLYN, N.Y. 11203   |  |   |  |
|   | 20e. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Cypress Hill Cem. FEB. 20, 1996   |  | 20c. Location - City or Town, State<br>BROOKLYN N.Y.  |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br>Thomas J. Skarda   |  | 22. Name and Address of Facility<br>SKARDA F.H. 2828 HUDSON ST. BALTO, MD. 21224  |  |   |  |
|   | 23e. Pert. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. SHOTGUN WOUND OF BACK AND GUNSHOT WOUNDS TO BACK AND BACK<br>Due to (or as a consequence of):<br>b. BACK AND BACK<br>Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  | Approximate Interval Between Onset and Death  |  |   |  |
| To Be Completed by Physician/Medical Examiner | Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |  |
|   | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) ELEVATOR SHAFT |  |   |  |
|   | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28e. Date of Injury (Month, Day Year)<br>2 10 96  |  | 28f. Time of Injury<br>1858 PM  |  |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>ABRAHAM BUILDING  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>311 CATHEDRAL ST. BALTIMORE MD  |  | 28d. Describe how injury occurred<br>SWINGING SHOT  |  |
|   | 29e. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. Signature and title of certifier<br>Monica Dore Howell   |  | 29c. License number<br>O.C.M.E.   |  |
| To Be Completed by Physician/Medical Examiner | 29d. Date signed (Month, Day, Year)<br>FEB. 10, 1996  |  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>M. RYAN A. KOWEN 111 Penn Street, Baltimore, Maryland 21201   |  |   |  |
|   | 31. Date filed (Month, Day, Year)<br>FEB 23 1996  |  | 32. Registrar's Signature<br>John A. [Signature]  |  |   |  |

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*[Faint, illegible text throughout the page, likely bleed-through from the reverse side.]*

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 046119

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MARY B. BOES</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>FEB.</b> DAY <b>16</b> YEAR <b>1996</b>   |  | 3. TIME OF DEATH<br><b>9:50 P</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>435-16-2906</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>88</b> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>OCT. 18, 1907</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>NEW ORLEANS LA.</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>MANOR CARE</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>CHEVY CHASE</b>  |  |
| 9c. COUNTY OF DEATH<br><b>MONTGOMERY</b>  |  |  |  | 10a. STATE<br><b>MD.</b>   |  | 10b. COUNTY<br><b>MONTGOMERY</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>CHEVY CHASE</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>8700 JONES MILL RD.</b>   |  |
| 10f. ZIP CODE<br><b>20815</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>HOMEMAKER</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>OWN HOME</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>JOHN BIANCA</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>AMILIA RUSSO</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Joy Choppin</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5513 30TH ST. N.W. WASHINGTON D.C. 20215</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) <b>ENTOMBMENT</b>                         |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, chapelatory or other place)<br><b>ST. VINCENT DEPAUL CEM 2-23-96</b>   |  | 20c. LOCATION — City or Town, State<br><b>NEW ORLEANS, LA.</b>   |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Thomas J. Skarda Jr.</b>   |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>SKARDA FH 2829 HUDSON ST. BALTO, MD. 21224</b>   |  |  |  | 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Generalized Carcinomatosis</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>Carcinoma of Breast and Ovary</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>DUE TO (OR AS A CONSEQUENCE OF):<br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Approximate Interval Between Onset and Death<br><b>1 year</b><br><b>3 years</b> |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                 |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>J. Neill Kennedy M.D.</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D13187</b>   |  | 29d. DATE SIGNED (Month/Day, Year)<br><b>2/17/96</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Dr. J. Neill Kennedy 5530 Wisconsin Ave. Chevy Chase, Md 20815</b>  |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 23 1996</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>John A. ...</b>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE REGISTRAR OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04620

|   |  |  |   |  |  |  |   |  |
|---|--|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>ANNA J. BORDEN   |  |   |  | 2. Date of Death<br>Month Day Year<br>FEBRUARY 21, 1996  |  | 3. Time of Death<br>2:51 P.M.   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>239 S. DUNCAN STREET   |  |   |  | 4b. City, Town, or Location of Death<br>BALTIMORE  |  | 4c. County of Death<br>N/A  |  |
| Funeral<br>Director                           | 5. Social Security Number<br>219-10-5896   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>69 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>07/27/1927   |  |
|   | 9. Birthplace (State or Foreign Country)<br>Maryland   |  | 10a. State<br>Maryland  |  | 10b. County<br>N/A   |  | 10c. City, Town or Location<br>Baltimore  |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |  | 10e. Street and Number<br>239 S. Duncan Street   |  | 10f. Zip Code<br>21231  |  |
|   | 10g. Citizen of What Country?<br>USA   |  |   |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify White  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8 College (1-4 or 5+) 0                            |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Waitress  |  |   |  | 16b. Kind of Business/Industry<br>Restaraunt   |  | 17. Father's Name (First, Middle, Last)<br>John Burdyski  |  |
| To Be Completed by Physician/Medical Examiner | 18. Mother's Name (First, Middle, Maiden Surname)<br>Stella Sczielecka   |  |   |  | 19a. Informant's Name/Relationship (Type, Print)<br>Edward W. Jaskulski Brotherinlaw   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>304 S. Conllington Ave. Baltimore, Md 21231      |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Greenmount Cemetery   |  | Date<br>02/23  |  | 20c. Location - City or Town, State<br>Baltimore, Maryland  |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br><i>David J. Weber</i>   |  |   |  | 22. Name and Address of Facility<br>David J. Weber Funeral Home<br>401 S. Chester Street Baltimore, Md 21231   |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <i>Atherosclerotic Cardiovascular Disease</i><br>Due to (or as a consequence of):<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  | Approximate Interval Between Onset and Death   |  |   |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |   |  |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred  |  |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  |
|   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |
| To Be Completed by Physician/Medical Examiner | 29b. Signature and title of certifier<br><i>Dennis J. Chute MD</i>   |  |   |  | 29c. License number<br>O.C.M.E.  |  | 29d. Date signed (Month, Day, Year)<br>FEBRUARY 22, 1996  |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Dennis J. Chute MD   |  |   |  | 111 Penn Street, Baltimore, Maryland 21201   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 31. Date filed (Month, Day, Year)<br>FEB 23 1996   |  |   |  | 32. Registrar's Signature<br><i>Julia H. Pearson-Randall</i>   |  |   |  |
|   | 33. Registrar's Name<br>Julia H. Pearson-Randall   |  |   |  |  |  |   |  |

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1. The first part of the document is a list of the names of the persons who were present at the meeting.

2. The second part of the document is a list of the names of the persons who were present at the meeting.

3. The third part of the document is a list of the names of the persons who were present at the meeting.

4. The fourth part of the document is a list of the names of the persons who were present at the meeting.

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12. The twelfth part of the document is a list of the names of the persons who were present at the meeting.

13. The thirteenth part of the document is a list of the names of the persons who were present at the meeting.

14. The fourteenth part of the document is a list of the names of the persons who were present at the meeting.

15. The fifteenth part of the document is a list of the names of the persons who were present at the meeting.

16. The sixteenth part of the document is a list of the names of the persons who were present at the meeting.

17. The seventeenth part of the document is a list of the names of the persons who were present at the meeting.

18. The eighteenth part of the document is a list of the names of the persons who were present at the meeting.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 20 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

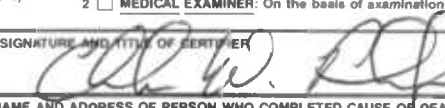

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04621

|   |  |  |   |   |  |  |  |   |  |   |  |  |  |
|---|--|--|---|---|--|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Frances Bergeda Bowen   |  |  |   | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>FEB. 20, 1996   |  |  |  | 3. TIME OF DEATH<br>1415 M  |  |   |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br>577-40-3405  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br>66 YRS. | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS.<br>HOURS MIN.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>Feb. 9, 1930  |  | 8. BIRTHPLACE (State or Foreign Country)<br>New York  |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Anne Arundel Medical Center   |  |  |   | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Annapolis  |  |  |  | 9c. COUNTY OF DEATH<br>Anne Arundel   |  |   |  |  |  |
| RESIDENCE OF DECEDENT   |  |  |   |   |  |  |  |   |  |   |  |  |  |
| 10a. STATE<br>MD  |  | 10b. COUNTY<br>Anne Arundel  |   | 10c. CITY, TOWN OR LOCATION<br>Shady Side   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |   |  |  |  |
| 10e. STREET AND NUMBER<br>1203 Boarman Lane   |  |  |   | 10f. ZIP CODE<br>20764  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  |   |  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |   | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                                    |  |   |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 9 College (1-4 or 5+) 9   |  |  |   | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>School Bus Aide  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>AACo.Bd of Education  |  |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>George Daniel MacLean Sr.  |  |  |   | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Mary Margaret Gillis   |  |  |  |   |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Terri Lumpkin   |  |  |   | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4926 Bonniewood Drive, Shady Side, MD 20764  |  |  |  |   |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Maryland Veterans Cem. 2/23   |   |   |  | OATE   |  | 20c. LOCATION — City or Town, State<br>Crownsville, MD  |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |   | 22. NAME AND ADDRESS OF FACILITY<br>Hardesty Funeral Home, P.A.<br>12 Ridgely Ave. Annapolis, MD 21401  |  |  |  |   |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>large cell lung Ca</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. _____<br>c. _____<br>d. _____ |  |  |   |   |  |  |  |   |  | Approximate Interval Between Onset and Death<br>6 months  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>CoPD</u>   |  |  |   |   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |   |   |  |  |  |   |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |  |  |  |   |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |   | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |   | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |   |   |  |  |  |   |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br> MD   |  |  |   |   |  | 29c. LICENSE NUMBER<br>D41816  |  | 29d. OATE SIGNED (Month, Day, Year)<br>2/21/96  |  |   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Charles W. Phelps, 180 Admiral Cochrane Dr., Annapolis, Md. 21401  |  |  |   |   |  |  |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>FEB 23 1996  |  |  |   | 32. REGISTRAR'S SIGNATURE<br>  |  |  |  |   |  |   |  |  |  |

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04622

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Carrie Bryan

2. Date of Death

February 17, 1996

3. Time of Death

1:47p.m.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

720 Arlington Avenue

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

n/a

5. Social Security Number

226-20-9710

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

April 8, 1915

9. Birthplace (State or Foreign Country)

Va.

Usual Residence of Decedent

10a. State

Md.

10b. County

n/a

10c. City, Town or Location

Baltimore

10d. Inside City Limits

NO Yes 2 ☐ No

10e. Street and Number

720 Arlington Avenue

10f. Zip Code

21217

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

Collage (1-4 or 5+)

1 yr.

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Tailor

16b. Kind of Business/Industry

Self Employed

17. Father's Name (First, Middle, Last)

John Baskerville

18. Mother's Name (First, Middle, Maiden Surname)

Jennie Bennett

19a. Informant's Name/Relationship (Type, Print)

Sandra Turner Goodnight

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

310 Gawain Ct. Richmond, Va.

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory, etc.)

Metro/ ~~Mt. Auburn~~ Crematory

Date

2/21

20c. Location - City or Town, State

Balto., Md.

21. Signature of Funeral Service Licensee

James A. Morton

22. Name and Address of Facility

James A. Morton &amp; Sons

1701 Laurens St. Balto., Md. 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

e.

Ventricular Aneurysm

Due to (or as a consequence of):

b.

Coronary Insufficiency

Due to (or as a consequence of):

c.

Coronary Atherosclerosis

Due to (or as a consequence of):

d.

Hypertension

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

0 ASD 3 Bruise CA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury et

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

James A. Morton

29c. License number

D111467

29d. Date signed (Month, Day, Year)

2/20/96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

MARSH T. BROWN JR 301 pr. Paul Brown suite 214

31. Date filed (Month, Day, Year)

FEB 23 1996

Registrar's Signature

J. A. Morton

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar

SS222



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 96 04623

|  |  |  |   |   |   |  |  |  |
|--|--|--|---|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Dorothy Marie Butler   |  |   |   | 2. Date of Death<br>Month February Day 17, Year 1996  |  | 3. Time of Death<br>10:50a   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Union Memorial Hospital  |  |   |   | 4b. City, Town, or Location of Death<br>Baltimore   |  | 4c. County of Death<br>N/A   |  |
| Funeral<br>Director  | 5. Social Security Number<br>212-60-2532   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br>43 Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br>Nov 24, 1952                                  |  |
|  | 9. Birthplace (State or Foreign Country)<br>Maryland   |  | 10a. State<br>Md.   |   | 10b. County<br>N/A  |  | 10c. City, Town or Location<br>Baltimore   |  |
| To Be Completed by<br>Funeral Director   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 10e. Street and Number<br>4528 St. Georges Avenue   |   | 10f. Zip Code<br>21212  |  | 10g. Citizen of What Country?<br>USA   |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: Black                     |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 10th  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Clerk                                    |   | 16b. Kind of Business/Industry<br>Laundry   |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>Samuel Leathers   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Bettye Lucille Pride   |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>Bettye L. Aaron Mother   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4528 St. Georges Ave. Baltimore, Md 21212  |  |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Mt. Zion Cemetery   |   | 20c. Location - City or Town, State<br>Lansdowne, Md.   |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br>Caple Funeral Service<br>5502 Winner Avenue Baltimore, Md. 21215  |   |   |  |  |  |
|  | 23a. Part I. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>a. Multiple Organ Failure<br>Due to (or as a consequence of):<br>b. AIDS<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br><br>Approximate Interval Between Onset and Death<br>7 days<br>9 yrs. |  |   |   |   |  |  |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |   |   |   |  |  |  |
|  | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |   |   |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |  |   |   |   |  |  |  |
| Physician<br>/Medical<br>Examiner  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  |  |  |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|  | 28d. Describe how Injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
|  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                      |  |   |   |   |  |  |  |
| State<br>Registrar   | 29b. Signature and title of certifier<br>Sharon D. Allison MD  |  |   |   | 29c. License number<br>AT243846-132   |  | 29d. Date signed (Month, Day, Year)<br>Feb 17, 1996                                  |  |
|  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>Sharon D. Allison 201 East University Pkwy Balto, Md 21218-2895  |  |   |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br>FEB 23 1996   |  |  |   | 32. Registrar's Signature<br>Julia Davidson-Randall |   |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

CS22 20

5

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

Reg. No. 96 04624

|  |   |   |   |  |   |  |
|--|---|---|---|--|---|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedant's Name (First, Middle, Last)<br>DANTA JEVON DONTE BELLIN  |   | 2. Date of Death<br>Month Day Year<br>FEBRUARY 19, 1996   |  | 3. Time of Death<br>0003AM  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>BAYVIEW MEDICAL CENTER E.R.   |   | 4b. City, Town, or Location of Death<br>BALTIMORE CITY  |  | 4c. County of Death<br>n/a  |  |
| Funeral<br>Director  | 5. Social Security Number<br>215-96- 3030   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>15 Yrs.   |  |
|  | 8. Date of Birth<br>(Month, Day, Year)<br>JULY 4, 1980  |   | 9. Birthplace (State or Foreign Country)<br>BALTIMORE, MD   |  |   |  |
| To Be Completed by Funeral Director                                  | Usual Residence of Decedant   |   |   |  |   |  |
|  | 10a. State<br>MD  |   | 10b. County<br>n/a  |  | 10c. City, Town or Location<br>BALTIMORE  |  |
|  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |   |  |   |  |
|  | 10e. Street and Number<br>5509 BOWLEYS LANE APT. 4c   |   | 10f. Zip Code<br>21206  |  | 10g. Citizen of What Country?<br>UNITED STATES  |  |
|  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedant Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedant of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: BLACK  |   |   |  |   |  |
|  | 15. Decedant's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>8 th -  |   | 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>STUDENT  |  | 16b. Kind of Business/Industry<br>JR. HIGH  |  |
|  | 17. Father's Name (First, Middle, Last)<br>PHILLIP WALLACE  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>TERRY BELIN  |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>TERRY BELIN   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>5509 BOWLEYS LANE, BALTIMORE, MD apt. 4c# 06   |  |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>AIMWEL BAPTIST CH. CEM.   |  | 20c. Location - City or Town, State<br>2-24 PAMILICO, S. CAROLINA   |  |
| 21. Signature of Funeral Service Licensee<br>                        |   | 22. Name and Address of Facility<br>WM. C. MARCH FH.-1101 E. NORTH AVENUE |   |  |   |  |
| Physician<br>/Medical<br>Examiner                                    | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Multiple Injuries<br>Due to (or as a consequence of):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of): |   |   |  |   | Approximate Interval Between Onset and Death   |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
|  |   |   |   |  |   | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |
|  |   |   |   |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |
|  | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)<br>2/19/96   |  | 28b. Time of Injury<br>2250 PM  |  |
|  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 28d. Describe how injury occurred<br>motor vehicle collision  |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)<br>Baltimore, Md   |  |
|  | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   | 29b. Signature and title of certifier<br>   |  | 29c. License number<br>O.C.M.E.   |  |
| State Registrar  | 29d. Date signed (Month, Day, Year)<br>FEBRUARY 19, 1996  |   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Dennis J. Chute M.D. 111 Penn Street, Baltimore, Maryland 21201   |  |   |  |
|  | 31. Date filed (Month, Day, Year)<br>FEB 23 1996  |   | 32. Registrar's Signature<br>   |  |   |  |



1 - FOR  
STATE  
REGISTRAR

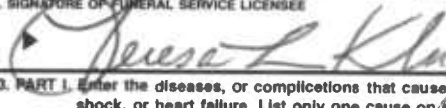

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04625

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Charlotte, Cogswell</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>Feb</b> DAY <b>21</b> YEAR <b>96</b>  |  | 3. TIME OF DEATH<br><b>07:48 AM</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>220-36-0798</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br><b>55</b> YRS. | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>   |  | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b>  |  |
| 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>JUNE 21, 1940</b>   |  |  |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>MARYLAND</b>  |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>ST. AGNES HOSPITAL</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>  |  | 9c. COUNTY OF DEATH<br><b>BALTIMORE CITY</b>  |  |
| RESIDENCE OF DECEDENT  |  |  |  |  |  |   |  |
| 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY<br><b>ANNE ARUNDEL</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>MILLERSVILLE</b>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO       |  |
| 10e. STREET AND NUMBER<br><b>557 JANDON COURT</b>  |  |  |  | 10f. ZIP CODE<br><b>21108</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A..</b>   |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                               |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12TH GRADE</b><br>College (1-4 or 5+) <b>College</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>SECRETARY</b>            |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>WESTINGHOUSE</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>THOMAS W. COGSWELL</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>LOTTIE A. WAGNER</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>SARA SAVILLA TEIGER</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2520 WILLOW GLEN DRIVE - BALTIMORE, MD 21209</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>LOUDBON PARK CEMETERY</b>                              |  | DATE<br><b>2/24</b>  |  | 20c. LOCATION — City or Town, State<br><b>BALTIMORE</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>HUBBARD FUNERAL HOME, INC.<br/>4107 WILKENS AVENUE-BALTIMORE, MD 21229</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |  |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  | a. <b>CARDIOPULMONARY failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  | Approximate Interval Between Onset and Death<br><b>2 Day</b>  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  | b. <b>Diabetes</b><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  | <b>20yr</b>   |  |
|  |  | c. <b>Ischemic CARDIO myopathy</b><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  | <b>5yr</b>  |  |
|  |  | d. <b>CORONARY Artery disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  | <b>7yr</b>  |  |
|  |  |  |  |  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO           |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                          |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Allen Reilly, MD Resident</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>PO 9138</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>Feb, 21, 1996</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>ST. Agnes Hospital 900 Caton Ave; Baltimore, MD 21229</b>  |  |  |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 23 1996</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |   |  |

20052



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04626

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

NANCY CORDELL CRAWFORD

2. Date of Death

Month Day Year  
FEBRUARY 21, 1996

3. Time of Death

10:45 A.M.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

529 ROSSITER ROAD

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE

5. Social Security Number

226-10-6102

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

93

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
APRIL 6, 1903

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

529 ROSSITER ROAD

10f. Zip Code

21212

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No.

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

4TH GRADE

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

HOMEMAKING

17. Father's Name (First, Middle, Last)

AHAZ SHIFFLETT

18. Mother's Name (First, Middle, Maiden Surname)

SARAH UNKNOWN

19a. Informant's Name/Relationship (Type, Print)

MR. HENRY LEE CRAWFORD

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

108 WOODS ROAD - QUEENSTOWN, MARYLAND 21658

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

WOODLAWN CEMETERY

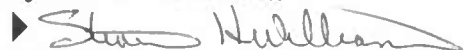
Date

2/24/96

20c. Location - City or Town, State

BALTIMORE

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

HUBBARD FUNERAL HOME, INC.

4107 WILKENS AVENUE-BALTIMORE, MD 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)a. Due to (or as a consequence of):  
Coronary artery disease

b. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier



29c. License number

D 28266

29d. Date signed (Month, Day, Year)

2.21.96

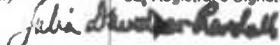
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. AYE LWIN - 5010 YORK ROAD - BALTIMORE, MD 21212

31. Date filed (Month, Day, Year)

FEB 23 1996

32. Registrar's Signature


State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04627

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARY MARGARET COLL

2. Date of Death

Month

Day

Year

FEBRUARY 21 1996

3. Time of Death

0410 A

4a. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST HOSP.

4b. City, Town, or Location of Death

GAITHERS BURG

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

185-18-2463

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

AUG. 15, 1918

9. Birthplace (State or Foreign Country)

NEW SALEM, PA

Usual Residence of Decedent

10a. State

PA.

10b. County

ALLEGHENY

10c. City, Town or Location

CORAOOLIS

10d. Inside City Limits

☐ Yes ☒ No

10e. Street end Number

129 NYETIMBER PARKWAY

10f. Zip Code

15108

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOME MAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

HARRY TURNEY

18. Mother's Name (First, Middle, Maiden Surname)

MARGARET STEWART

19e. Informant's Name/Relationship (Type, Print)

ROGER A. COLL

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)

129 NYETIMBER PARKWAY CORAOOLIS PA. 15108

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

SEWICKLEY CEM. FEB. 24, 1996 SEWICKLEY, PA.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Thomas J. Skarda

22. Name and Address of Facility

SKARDA F.H. 2829 HUDSON ST. BALTO., MD. 21224

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. BRONCHIECTASIS

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

20 YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

OSTEO POROSIS WITH COMPRESSION

FRACTURE

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24e. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ 4 Nursing Home☐ 5 Residence☐ 6 Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ 5 Pending investigation☐ 6 Could not be determined

28e. Date of Injury (Month, Day Year)

28f. Time of Injury

M

28g. Injury at Work?

☐ Yes ☒ No

28h. Describe how injury occurred

28i. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ 1 Certifying Physician☐ 2 Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Carl I. Schoenberg, MD

29c. License number

D 26540

29d. Date signed (Month, Day, Year)

FEB 21 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Carl I. Schoenberg 16220 Friedricks Rd. Gaithersburg

31. Date filed (Month, Day, Year)

FEB 23 1996

32. Registrar's Signature

Julia Bruckner

State  
Registrar

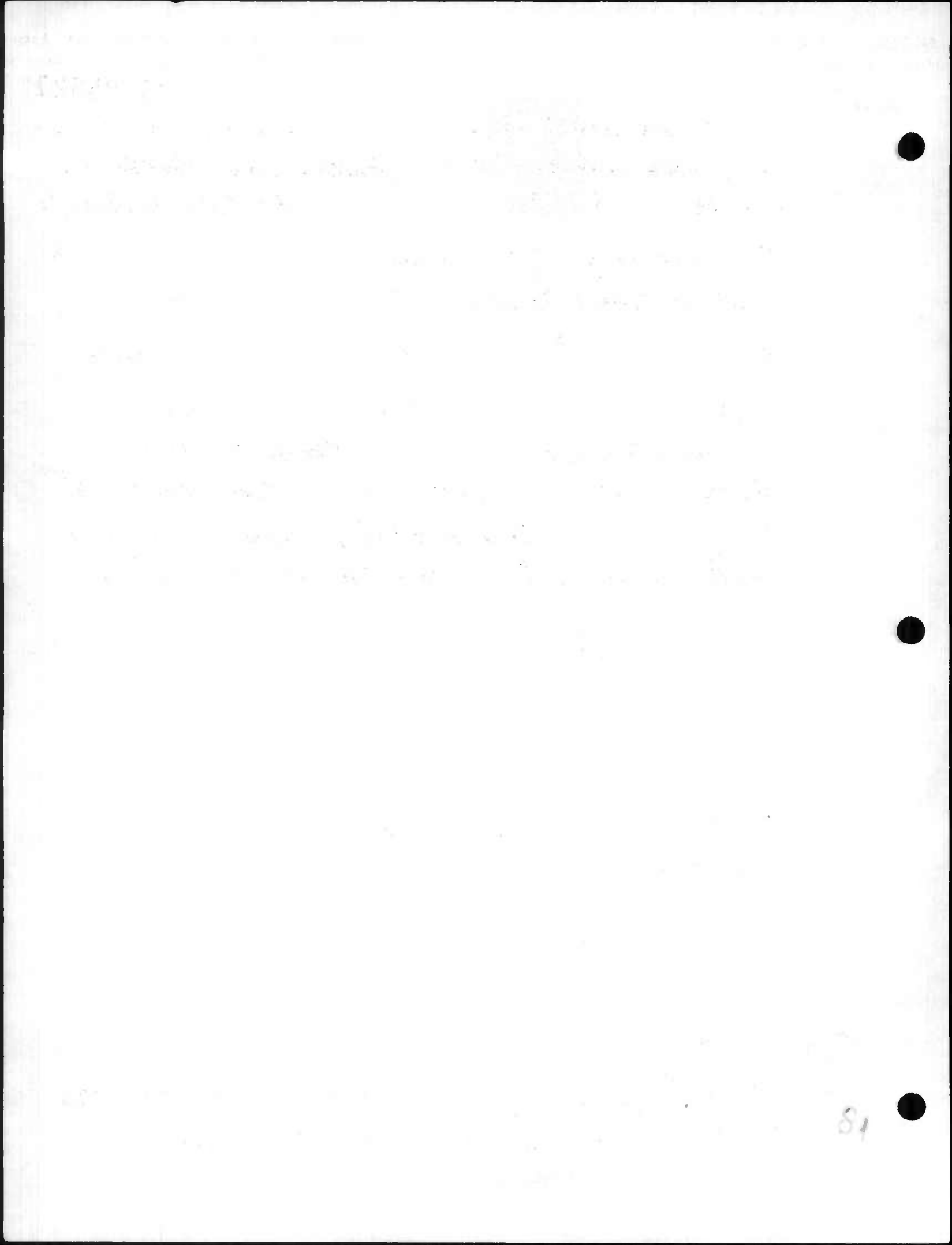
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04628

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Louise M. Courtney

2. Date of Death

Month Day Year  
Feb 22 1996

3. Time of Death

10:10 AM

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Bayview M.C.

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

217-03-3925

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Sep 30, 1917

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Md

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1257 Delbert Ave

10f. Zip Code

21222

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

8

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Herman Freitag

18. Mother's Name (First, Middle, Maiden Surname)

Anna Beabel

19e. Informant's Name/Relationship (Type, Print)

Juanita Johnson / daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1257 Delbert Ave Baltimore, Md 21222

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Holy Redeemer Cem

Date

2/24/96

20c. Location - City or Town, State

Baltimore, Md

21. Signature of Funeral Service Licensee

Anthony C. Connelly

22. Name and Address of Facility

Connelly Funeral Home of Dundalk

7110 Sollers Point Rd 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ARRHYTHMIA

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

24 HOURS

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. ANEMIA

Due to (or as a consequence of):

2 Mo.

c. CALCIFIC PANCREATITIS

Due to (or as a consequence of):

6 Mo.

d. BLADDER MASS

2 Mo.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28e. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Belinda J. Chen, M.D.

29c. License number

D46289

29d. Date signed (Month, Day, Year)

2/23/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BELINDA CHEN, M.D. 40 S. DUNDALK AVE BALT, MD 21222

31. Date filed (Month, Day, Year)

FEB 23 1996

32. Registrar's Signature

Julia M. ...

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

asp

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 96 04629

|   |  |  |   |  |  |  |   |  |
|---|--|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>JOHN FRANCIS CARROLL III   |  |   |  | 2. Date of Death<br>Month FEB Day 19 Year 1996   |  | 3. Time of Death<br>2:03 A  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>BAYVIEW HOSPITAL   |  |   |  | 4b. City, Town, or Location of Death<br>BALTIMORE  |  | 4c. County of Death<br>n/a  |  |
| Funeral<br>Director   | 5. Social Security Number<br>220-84-8773   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>20 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>NOV. 25, 1975  |  |
|   | 9. Birthplace (State or Foreign Country)<br>BALTIMORE, MD  |  | 10a. State<br>MD  |  | 10b. County<br>n/a   |  | 10c. City, Town or Location<br>BALTIMORE  |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 10e. Street and Number<br>1201 N. CAROLINE STREET   |  | 10f. Zip Code<br>21205   |  | 10g. Citizen of What Country?<br>UNITED STATES  |  |
|   | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: BLACK                                |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 10 th College (1-4 or 5+) ---   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Laborer                              |  | 16b. Kind of Business/Industry<br>various trades   |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br>JOHN F RANCIS CARROLL JR.   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>RUTHIE CARROLL  |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>+ JOHN & ANNIE CARROLL   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>485-20 MATTAPANY ROAD, LEXINGTON PK, MD 20653   |  |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>VOSHALL MEMORIAL GARDENS 2-23   |  | 20c. Location - City or Town, State<br>DUNDALK, MD   |  |   |  |
|   | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |  |   |  | 22. Name and Address of Facility<br>WM. C. MARCH FH.-1101 E. NORTH AVENUE  |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. Multiple Gun shot wounds<br>Due to (or as a consequence of):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |  |   |  |  |  |   |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |   |  |  |  |   |  |
|   | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |  |  |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |   |  |  |  |   |  |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.<br>To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.<br>Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once. | 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |  |  |  |   |  |
|   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |   |  |  |  |   |  |
|   | 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)<br>2-19-16   |  | 28b. Time of Injury<br>12 44 AM  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
|   | 28d. Describe how injury occurred<br>Subject shot  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>Street  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>1400 blk Gusman Av   |  |   |  |
| State Registrar   | 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  |  |   |  |
|   | 29b. Signature and Title of Certifier<br><i>[Signature]</i>  |  |   |  | 29c. License number<br>O.C.M.E   |  | 29d. Date signed (Month, Day, Year)<br>FEBRUARY 19, 1996  |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>David R Fowler 111 Penn Street, Baltimore, Maryland 21201  |  |   |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br>FEB 23 1996  |  |  |   |  |  |  |   |  |
| 32. Registrar's Signature<br><i>[Signature]</i>   |  |  |   |  |  |  |   |  |

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR   |  |   |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |                                |   |   | REG. NO.  |                                       | 96 04630  |  |
|---|--|---|--|---|--------------------------------|---|---|---|---------------------------------------|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>NICHOLAS PAUL D'ANDREA</b>   |  |   |  |   |                                | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>February 19 1996</b>                               |   | 3. TIME OF DEATH<br><b>7:00 pm</b>  |                                       |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>116-12-5513</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 6. AGE (In yrs. last birthday)<br><b>84</b> YRS. | IF UNDER 1 YEAR<br>MONTHS DAYS  | IF UNDER 24 HRS.<br>HOURS MIN. | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Feb. 27, 1911</b>                              |   | 8. BIRTHPLACE (State or Foreign Country)<br><b>New York</b>                                     |                                       |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Fallston General Hospital</b>  |  |   |  |   |                                | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Fallston</b>                                      |   |   | 9c. COUNTY OF DEATH<br><b>Harford</b> |   |  |
| RESIDENCE OF DECEDENT   |  |   |  |   |                                |   |   |   |                                       |   |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Harford</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Edgewood</b>  |                                |   |   | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |                                       |   |  |
| 10e. STREET AND NUMBER<br><b>602 Banyan Court</b>   |  |   |  |   |                                | 10f. ZIP CODE<br><b>21040</b>   |   | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |                                       |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |                                |   | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b> |   |                                       |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b> <b>College (1-4 or 5+)</b>   |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Distribution Supervisor</b>   |                                |   | 16b. KIND OF BUSINESS/INDUSTRY<br><b>U.S. Army</b>                      |   |                                       |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Dominick D'Andrea</b>   |  |   |  |   |                                | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Barbara Ruggiero</b>                |   |   |                                       |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Isabella D'Andrea (Wife)</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>602 Banyan Court, Edgewood, Md. 21040</b>   |                                |   |   |   |                                       |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Highview Memorial Gardens 2/23/96</b>   |  |   |                                | 20c. LOCATION — City or Town, State<br><b>Fallston, Maryland</b>                            |   |   |                                       |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Robert J. Schuch</b>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Schimunek Funeral Home of Bel Air, Inc.<br/>610 W. MacPhail Road, Bel Air, Md. 21014</b>   |                                |   |   |   |                                       |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>End stage Respiratory failure</b><br><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>Severe chronic obstructive pulmonary disease<br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Severe coronary artery disease, C IHT</b> |  |   |  |   |                                |   |   |   |                                       | Approximate interval between Onset and Death<br><b>1 yr</b><br><b>10 yrs</b>                          |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>   |  |   |  |   |                                |   |   |   |                                       | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |                                |   |   |   |                                       |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |                                | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   | 28d. DESCRIBE HOW INJURY OCCURRED   |                                       |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Attending</b>   |                                |   |   | 29c. LICENSE NUMBER<br><b>D-16444</b>   |                                       | 29d. DATE SIGNED (Month, Day, Year)<br><b>Feb 19th 1996</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>VIJAY S. NAIR M.D. - 2112 BELAIR RD. FALLSTON. MD 21047.</b>  |  |   |  |   |                                |   |   |   |                                       |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 23 1996</b>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><b>Johi Andrew Carroll</b>   |                                |   |   |   |                                       |   |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Items: 23 part I, 27 per ME0 G-73. 3/1/96 Certificate of Death

Reg. No. 96 04631

Physician  
/Medical  
Examiner

Funeral  
Director

|   |  |   |  |   |  |  |
|---|--|---|--|---|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>MILDRED A. DUDLEY</b>  |  | 2. Date of Death<br>Month <b>FEB.</b> Day <b>17</b> Year <b>1996</b>  |  | 3. Time of Death<br><b>9:59 PM.</b>   |  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>421 N. COLLINGTON AVE.</b>   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>  |  | 4c. County of Death<br><b>N/A</b>   |  |  |
| 5. Social Security Number<br><b>220-22-9135</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>68</b> Yrs.  |  |  |
| 8. Date of Birth (Month, Day, Year)<br><b>March 9, 1927</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  |   |  |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>N/A</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>   |  |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>421 North Collington Avenue</b>  |  | 10f. Zip Code<br><b>21231</b>   |  |  |
| 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  | 11. Marital Status<br><input type="checkbox"/> Navar Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6th grade</b><br>College (1-4 or 5+) <b>Collage (1-4 or 5+)</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |  | 16b. Kind of Business/Industry<br><b>Own Home</b>   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Henry Gerber</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Emma R. Busler</b>  |  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Patricia Ches (Friend)</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7913 Lansdale Road, Baltimore, Maryland 21224</b>   |  |   |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Cedar Hill Cemetery 2/22/96</b>  |  | 20c. Location - City or Town, State<br><b>Glen Burnie, Maryland</b>   |  |  |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Schimunek Funeral Home<br/>3331 Brehms Lane, Baltimore, Maryland 21213</b>   |  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. CIRRHOSIS</b><br>Due to (or as a consequence of):<br><b>b. CHRONIC ALCOHOLISM</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |   |  | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |  |   |  |  |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |  |   |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |  |   |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  | 28d. Describe how injury occurred   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |   |  |  |
| 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>O.C.M.E.</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>FEB. 18, 1996</b>   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dennis J. Chute 111 Penn Street, Baltimore, Maryland 21201</b>   |  |   |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 23 1996</b>   |  | 32. Registrar's Signature<br>  |  |   |  |  |

To Be Completed by Funeral Director

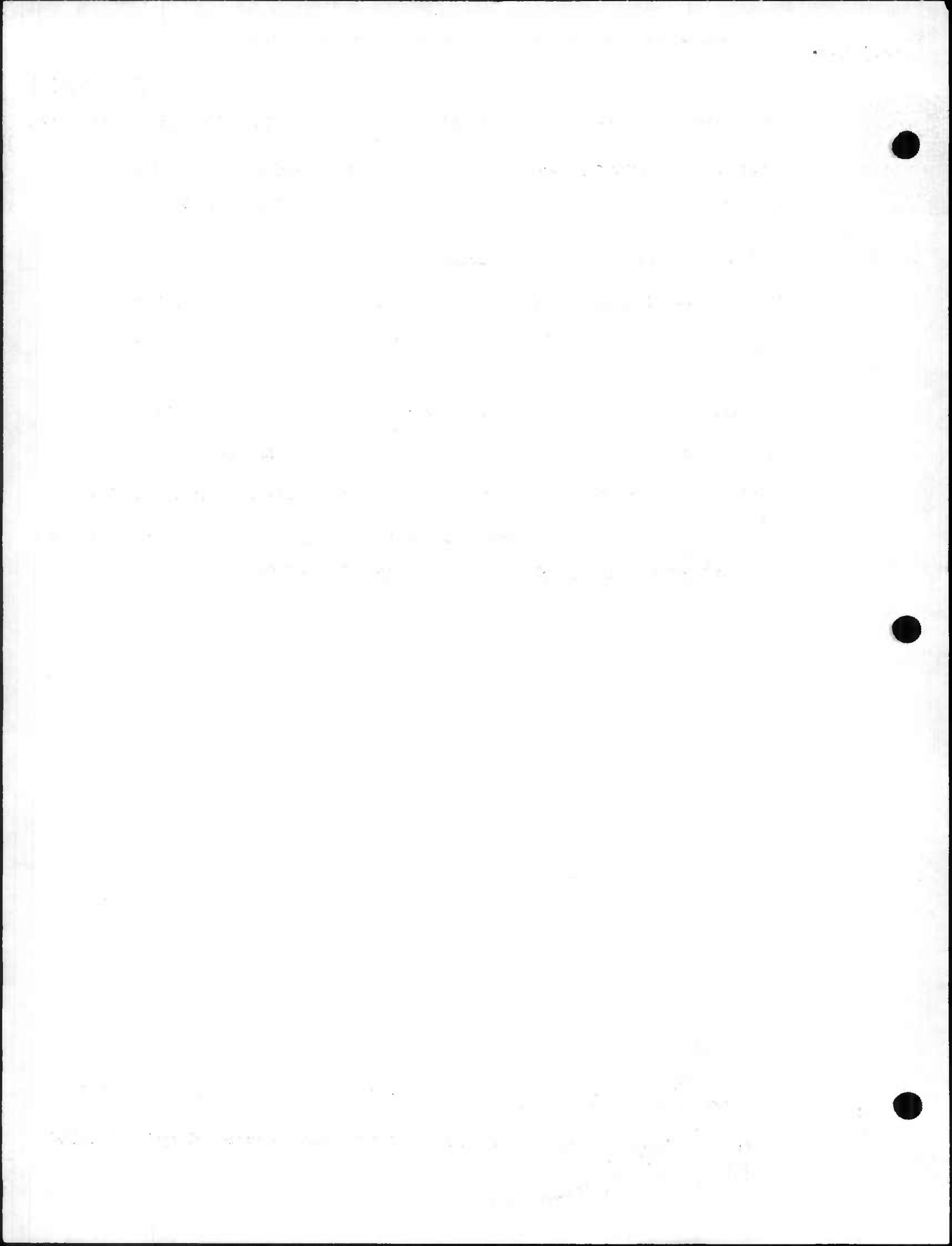
Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Items #10.e.19.b.G-film 732 per fh. 2/23/96 P.C

FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04632

|   |  |   |  |   |  |  |                            |   |  |   |  |
|---|--|---|--|---|--|--|----------------------------|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>EMMETT V. DiBERARDINE   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>Feb. 15, 1996   |  | 3. TIME OF DEATH<br>9:54 p.m.  |                            |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br>214-20-9552  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>70 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>Jan 11, 1926                               |                            | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Hopkins Bayview Medical Center  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore  |  |  | 9c. COUNTY OF DEATH<br>n/a |   |  |   |  |
| RESIDENCE OF DECEDENT   |  |   |  | 10a. STATE<br>Maryland  |  | 10b. COUNTY<br>n/a   |                            | 10c. CITY, TOWN OR LOCATION<br>Baltimore  |  |   |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |   |  | 10e. STREET AND NUMBER<br>125 South Clinton St.   |  | 10f. ZIP CODE<br>21224   |                            | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>WW II   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                  |                            |   |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12 th  |  | 15a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Traffic Manager  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Bakery  |  |  |                            |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>James DiBerardine  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Clara Argenteria   |  |  |                            |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Elizabeth DiBerardine   |  |   |  | 19b. MAILING ADDRESS (Name of Street, Number or Rural Route Number, City or Town, State, Zip Code)<br>125 S. Clinton St. Baltimore, Md. 21224   |  |  |                            |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>All Saints Cemetery 2-19   |  | 20c. LOCATION — City or Town, State<br>Wilmington, DE   |  |  |                            |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Johnny L. Goble</i>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>Duda-Ruck Funeral Home of Dundalk<br>7922 Wise Ave. Dundalk, Md. 21222  |  |  |                            |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Myocardial Infarction</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <i>Coronary artery Disease</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |   |  |   |  |  |                            | Approximate Interval Between Onset and Death<br><i>1 hr</i><br><i>1 hr</i>                                |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |   |  |   |  |  |                            | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |                            |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |                            | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |                            |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |  |                            |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Simon Scalia</i>  |  |   |  | 29c. LICENSE NUMBER<br>D 24276  |  | 29d. DATE SIGNED (Month, Day, Year)<br>2-16-96                                       |                            |   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Dr. Simon Scalia Old Lyme Rd. #10  |  |   |  |   |  |  |                            |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>FEB 23 1996  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |  |                            |   |  |   |  |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

3601

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

Reg. No. **96 04688**

|  |   |  |   |   |  |  |   |  |  |  |  |
|--|---|--|---|---|--|--|---|--|--|--|--|
| <b>Physician<br/>/Medical<br/>Examiner</b>   | 1. Decedent's Name (First, Middle, Last)<br><b>DOROTHY J. DIMELER</b>         |  |   |   |  |  | 2. Date of Death<br>Month <b>February</b> Day <b>20</b> Year <b>1996</b>                    |  | 3. Time of Death<br><b>7:01 PM</b>   |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>UMMS</b> |  |   |   |  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>                                    |  | 4c. County of Death<br><b>N/A</b>  |  |  |
| <b>Funeral<br/>Director</b>  | 5. Social Security Number<br><b>217-38-5424</b>                               |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>54</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>MAR. 29, 1941</b>                                 |  | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>                                    |  |  |
|  | Usual Residence of Decedent   |  |   |   |  |  |   |  |  |  |  |
| 10a. State<br><b>MARYLAND</b>  |   |  | 10b. County<br><b>N/A</b>   |   | 10c. City, Town or Location<br><b>BALTIMORE</b>  |  |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |
| 10e. Street and Number<br><b>1320 MCHENRY STREET</b>   |   |  |   |   | 10f. Zip Code<br><b>21223</b>  |  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)  |   |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOMEMAKER</b>  |  |   | 16b. Kind of Business/Industry<br><b>OWN HOME</b>  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>MELVIN MOWREY, SR.</b>   |   |  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>DOROTHY SHERR</b>  |   |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>JEROME E. DIMELER, SR./HUSBAND</b>  |   |  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1320 MCHENRY STREET, BALTIMORE, MARYLAND 21223</b> |   |  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>LOUDON PARK CEMETERY</b> |  |  | Date<br><b>FEB. 23, 1996</b>  |  | 20c. Location - City or Town, State<br><b>BALTIMORE, MARYLAND</b>                              |  |  |
| 21. Signature of Funeral Service Licensee<br><br><b>MO0877</b>   |   |  |   |   |  | 22. Name and Address of Facility<br><b>LOUDON PARK FUNERAL HOME, INC.<br/>3620 WILKENS AVENUE, BALTIMORE, MARYLAND 21229</b>                           |   |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |   |  |   |   |  |  |   |  |  | Approximate Interval Between Onset and Death<br><b>10 DAYS</b>   |  |
| <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>a. <b>CEREBRAL HERNIATION SYNDROME</b><br/>Due to (or as a consequence of):</p> <p>b. <b>ANEURYSMAL SUBARACHNOID HEMORRHAGE</b><br/>Due to (or as a consequence of):</p> <p>c. _____<br/>Due to (or as a consequence of):</p> <p>d. _____<br/>Due to (or as a consequence of):</p> </div> <div style="width: 35%; border-left: 1px solid black; padding-left: 10px;"> <p>10 DAYS</p> </div> </div> |   |  |   |   |  |  |   |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |  |   |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |  |
|  |   |  |   |   |  |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |   |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |   |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |  |
|  |   |  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   |  | 29b. Signature and title of certifier<br><br><b>MD</b>  |   |  | 29c. License number<br><b>7301</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>FEBRUARY 20, 1996</b>  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DAVID HARTER, 22 GROVEN ST., BALTIMORE MD, 21201</b>  |   |  |   |   |  |  |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 23 1996</b>  |   |  | 32. Registrar's Signature<br>   |   |  |  |   |  |  |  |  |





TO THE HOSPITAL AT THE TIME OF DEATH: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR   |  |   |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 96 04634   |  |   |  |
|--|--|---|--|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)   |  |   |  | 2. DATE OF DEATH   |  |   |  | 3. TIME OF DEATH   |  |   |  |
| John Theodore Foster   |  |   |  | February 18, 1996  |  |   |  | 7:30 A.M.  |  |   |  |
| 4. SOCIAL SECURITY NUMBER  |  | 5. SEX  |  | 6. AGE (In yrs. last birthday)   |  | IF UNDER 1 YEAR   |  | IF UNDER 24 HRS.   |  | 7. DATE OF BIRTH  |  |
| 219-10-6088  |  | 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                              |  | 94 YRS.  |  | MONTHS DAYS HOURS MIN.  |  |  |  | Feb. 14, 1902   |  |
| 9a. FACILITY NAME (If not institution, give street and number)   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH  |  |   |  | 9c. COUNTY OF DEATH  |  |   |  |
| 801 Wise Avenue  |  |   |  | Dundalk  |  |   |  | Baltimore  |  |   |  |
| RESIDENCE OF DECEDENT  |  |   |  |  |  |   |  |  |  |   |  |
| 10a. STATE   |  | 10b. COUNTY   |  | 10c. CITY, TOWN OR LOCATION  |  | 10d. INSIDE CITY LIMITS?  |  |  |  |   |  |
| Maryland   |  | Baltimore   |  | Dundalk  |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |  |  |   |  |
| 10e. STREET AND NUMBER   |  |   |  | 10f. ZIP CODE  |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?  |  |   |  |
| 801 Wise Ave.  |  |   |  | 21222  |  |   |  | United States  |  |   |  |
| 11. MARITAL STATUS   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN?   |  | 14. RACE — American Indian, Black, White, etc.                          |  |  |  |   |  |
| 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  | Specify: White  |  |  |  |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)  |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)   |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |   |  |
| Elementary/Secondary (0-12) 12 Years   |  |   |  | College (1-4 or 5+) Machinist  |  |   |  | Manufacturing  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)  |  |   |  |  |  |   |  |
| Christopher Foster   |  |   |  | Sophia Ganter  |  |   |  |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)  |  |   |  |  |  |   |  |
| Hansi C. Foster  |  |   |  | 925 Short Road Dundalk, Maryland 21222   |  |   |  |  |  |   |  |
| 20a. METHOD OF DISPOSITION   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)                   |  | DATE   |  | 20c. LOCATION — City or Town, State                                     |  |  |  |   |  |
| 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | Crestlawn Cemetery  |  | 2/21/1996  |  | Marriottsville, Maryland  |  |  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  |  |   |  | 22. NAME AND ADDRESS OF FACILITY   |  |   |  |  |  |   |  |
| [Signature]  |  |   |  | Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222   |  |   |  |  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |  |  |   |  | Approximate Interval Between Onset and Death                                 |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiac arrest  |  |   |  |  |  |   |  | min  |  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. Severe Coronary Heart Disease  |  |   |  |  |  |   |  | years  |  |   |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |  |  |   |  |  |  |   |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |  |  |   |  |  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |  |
| Dry Gangrene L Foot (Toes)   |  |   |  |  |  |   |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO      |  | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |   |  |  |  |   |  |  |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?   |  |   |  | 26. PLACE OF DEATH (Check only one)  |  |   |  |  |  |   |  |
| 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |   |  | HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |   |  |
| 27. MANNER OF DEATH  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY  |  | 28c. INJURY AT WORK?  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  |
| 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |  |   |  | M  |  | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO            |  |  |  |   |  |
| 29a. CERTIFIER (Check only one)  |  |   |  | 29b. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 29c. LOCATION (Street and Number or Rural Route Number, City or Town, State) |  |   |  |
| 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  |  |   |  |  |  |   |  |
| 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |  |  |   |  |  |  |   |  |
| 29d. SIGNATURE AND TITLE OF CERTIFIER  |  |   |  | 29e. LICENSE NUMBER  |  |   |  | 29f. DATE SIGNED (Month, Day, Year)  |  |   |  |
| Sheldon H. Gottlieb, MD attending physician  |  |   |  | D16362   |  |   |  | 2/20/96  |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  |  |   |  |  |  |   |  |  |  |   |  |
| SHELDON H. GOTTLIEB MD 4940 EASTERN AVE BALTO MD 21224   |  |   |  |  |  |   |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)  |  |   |  | 32. REGISTRAR'S SIGNATURE  |  |   |  |  |  |   |  |
| FEB 23 1996  |  |   |  | [Signature]  |  |   |  |  |  |   |  |



item#1 film g732 2/23/96 ag

96 04635

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Anna R REIF Froehlich</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>Feb</b> DAY <b>17</b> YEAR <b>1996</b>  |  | 3. TIME OF DEATH<br><b>11:06 A M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>212-40-2734</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>93</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Aug. 27, 1902</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Howard County General Hospital</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Columbia</b>   |  |
| 9c. COUNTY OF DEATH<br><b>Howard</b>   |  |  |  | 10a. STATE<br><b>Pennsylvania</b>  |  | 10b. COUNTY<br><b>Lehigh</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Bethlehem</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>1631 Lois Lane</b>  |  |
| 10f. ZIP CODE<br><b>18018</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>  |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>8 Years</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Housewife</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Own Home</b>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>John Adam Reif</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Ann Staffel</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>S. Charles Froehlich</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>10087-4 Windstream Drive Columbia, MD 21044</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Oak Lawn Cemetery 2/21/1996</b>  |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, Maryland</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Duda-Ruck Funeral Home of Dundalk, Inc.<br/>7922 Wise Ave. Dundalk, MD 21222</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Septic Shock</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>Cholangitis</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>Cholelithiasis</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>Sequentially flat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b><br>Approximate Interval Between Onset and Death<br><b>24 hours</b><br><b>4 days</b><br><b>unknown</b> |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |  |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  |  |  |  |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>N/A</b>   |  | 28b. TIME OF INJURY<br><b>N/A</b>  |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE NOW INJURY OCCURED<br><b>N/A</b>   |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town)<br><b>N/A</b>  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Daniel A. Scott MD</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D43537</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>Feb 17 1996</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>6705 Sewells Orchard Dr Columbia MD 21045</b>  |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 23 1996</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



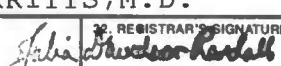
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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96 04636

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Richard Leroy Fry Sr.</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Feb. 17, 1996</b>  |  | 3. TIME OF DEATH<br><b>5:05a</b> M  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>222-07-8428</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>74</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Dec. 49, 1921</b>                                  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Kimbrough Army Hospital</b>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Ft. Meade</b>   |  | 9c. COUNTY OF DEATH<br><b>Anne Arundel</b>  |  |
| 10a. STATE<br><b>MD</b>  |  | 10b. COUNTY<br><b>Anne Arundel</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Odenton</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>516 Monterey Avenue</b>   |  |   |  | 10f. ZIP CODE<br><b>21113</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WWII Korea</b>   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                         |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b><br><b>12</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Civil Servant</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Ft. Meade</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Charles Fry</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Florence <del>Mark</del> Marks</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Ada Fry</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>516 Monterey Avenue, Odenton, MD 21113</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Ft. Indiantown Gap Nat'l Cem. 2/23</b>  |  | 20c. LOCATION — City or Town, State<br><b>PA</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Hardesty Funeral Home, P.A.<br/>12 Ridgely Ave. Annapolis MD 21401</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  |   |  |   |  |   |  |
| a. <b>FULL CARDIOPULMONARY ARREST</b><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |   |  |
| b. <b>INOPERABLE TERMINAL METASTATIC BRAIN CANCER</b><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |   |  |
| c. <b>DUE TO (OR AS A CONSEQUENCE OF):</b>   |  |   |  |   |  |   |  |
| d. <b>DUE TO (OR AS A CONSEQUENCE OF):</b>   |  |   |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  |   |  |   |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  |   |  |   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>  |  |   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><br><b>GARY W. MERRITTS, M.D.</b>  |  |   |  | 29c. LICENSE NUMBER<br><b>D32078</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>FEB 20, 1996</b>                                      |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>GARY W. MERRITTS, M.D. KIMBROUGH ARMY HOSPITAL, FT. MEADE, MD</b>  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 23 1996</b>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



96 04637

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |                                |   |  |
|---|--|--|--|---|--------------------------------|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Mary A. Furbusch</i>   |  |  |  | 2. DATE OF DEATH<br>MONTH <i>02</i> DAY <i>20</i> YEAR <i>1996</i>  |                                | 3. TIME OF DEATH<br><i>6:55 P.M.</i>  |  |
| 4. SOCIAL SECURITY NUMBER<br><i>220-18-5135</i>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br><i>95</i> YRS. | IF UNDER 1 YEAR<br>MONTHS DAYS  | IF UNDER 24 HRS.<br>HOURS MIN. | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>09/24/00</i>                                       |  |
| 8a. FACILITY NAME (If not institution, give street and number)<br><i>Meridian Multi-Med</i>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>7700 York Rd. Towson</i>  |                                | 8. BIRTHPLACE (State or Foreign Country)<br><i>Virginia</i>                                     |  |
| RESIDENCE OF DECEDENT   |  |  |  | 9c. COUNTY OF DEATH<br><i>Baltimore</i>   |                                |   |  |
| 10a. STATE<br><i>Md.</i>  |  | 10b. COUNTY<br><i>Balto</i>  |  | 10c. CITY, TOWN OR LOCATION<br><i>Turner Station</i>  |                                | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><i>679 S. Avonbeach Rd.</i>   |  |  |  | 10f. ZIP CODE<br><i>21222</i>   |                                | 10g. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |                                | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><i>Black</i>                      |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>6</i> College (1-4 or 5+) <i></i>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>Foster Care</i>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>State of Md.</i>   |                                |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Robert Coleman</i>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Louise Coleman</i>  |                                |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Marvin D. Williams</i>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>679 S. Avondale Rd. Balto, Md. 21222</i>  |                                |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Garrison Forest VA</i>   |  | DATE<br><i>2/26</i>   |                                | 20c. LOCATION — City or Town, State<br><i>Owings Mills, Md.</i>                                 |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>James A. Morton</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>James A. Morton &amp; Sons<br/>1701 Laurens St. Balto, Md. 21217</i>   |                                |   |  |
| 23. PART I. Enter the diseases, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>sepsis</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. <i></i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <i></i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <i></i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. <i></i> |  |  |  |   |                                |   | Approximate interval between Onset and Death<br><i>3d</i>  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>dementia</i>   |  |  |  |   |                                |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>   |  |  |  |   |                                |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |                                |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)<br><i>NA</i>   |  | 28b. TIME OF INJURY<br><i>M</i>   |                                | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |                                |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |                                |   |  |
| 29a. CERTIFIER <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |                                |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>   |  |  |  | 29c. LICENSE NUMBER<br><i>D41104</i>  |                                | 29d. DATE SIGNED (Month, Day, Year)<br><i>2-21-96</i>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>Ted Houk 7825 York Rd Towson MD 21204</i>   |  |  |  |   |                                |   |  |
| 31. DATE FILED (Month, Day, Year)<br><i>FEB 23 1996</i>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |                                |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1880-81



FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |   |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>JOHN Wesley Gray</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Feb. 20 96</b>   |  | 3. TIME OF DEATH<br><b>0252 M</b>   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>213-20-6093</b>  |  | 5. SEX<br><b>M</b>   |  | 6. AGE (In yrs. last birthday)<br><b>74</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Nov 21, 1924</b>  |   |
| 8. FACILITY NAME (If not institution, give street and number)<br><b>Deaton Speciality N.H.</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Balto</b>   |  | 9c. COUNTY OF DEATH<br><b>N/A</b>   |   |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |   |
| 10a. STATE<br><b>md</b>  |  | 10b. COUNTY<br><b>N/A</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Balto</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |   |
| 10e. STREET AND NUMBER<br><b>2812 Ellicott Driveway</b>  |  |  |  | 10f. ZIP CODE<br><b>21216</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>   |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WW II</b>   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>   |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6th</b> College (1-4 or 5+) <b>N/A</b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Supervisor</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>U.S. Postal Service</b>  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Basil Gray</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Rosie Travers</b>   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Rose E. Gray</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2812 Ellicott Driveway Balto, md 21216</b>  |  |   |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Woodlawn Cemetery</b>  |  | 20c. DATE<br><b>2/24/96</b>   |  | 20d. LOCATION — City or Town, State<br><b>Woodlawn, md</b>  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Gale March</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>March F.H. West<br/>4300 Wabash Ave</b>  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   |   |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  | a. <b>Metastatic bone carcinoma</b>  |  |   |  |   | Approximate Interval Between Onset and Death<br><b>1 yr</b> |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  |  | b. <b>Paraplegia</b>   |  |   |  |   | <b>"</b>  |
|  |  | c. <b>Neurogenic bladder</b>   |  |   |  |   | <b>"</b>  |
|  |  | d. <b>Diabetes mellitus</b>  |  |   |  |   | <b>"</b>  |
|  |  |  |  |   |  |   |   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   |   |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |   |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>  |  |  |  |   |  |   |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |   |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |   |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>[Signature]</b>  |  | 29c. LICENSE NUMBER<br><b>D30494</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>2/20/96</b>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>[Signature] 4660 Wilkes Ave Baltimore</b>  |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 23 1996</b>  |  | 32. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |   |  |   |   |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

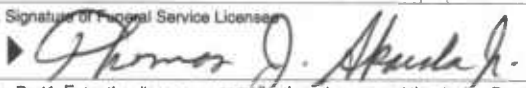
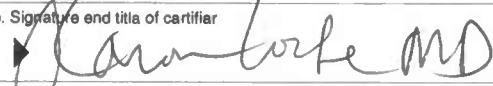
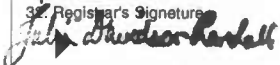
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1041



|  |  |  |   |   |  |  |   |   |  |  |  |
|--|--|--|---|---|--|--|---|---|--|--|--|
| <b>Physician<br/>/Medical<br/>Examiner</b>   | 1. Decedent's Name (First, Middle, Last)<br><b>SAMUEL GIBSON</b>   |  |   |   | 2. Date of Death<br>Month Day Year<br><b>FEB. 09, 1996</b>   |  | 3. Time of Death<br><b>5:00 PM</b>                                      |   |  |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>SINAI HOSPITAL</b>  |  |   |   | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |  | 4c. County of Death<br><b>N/A</b>                                       |   |  |  |  |
| <b>Funeral<br/>Director</b>  | 5. Social Security Number<br><b>550-17-4006</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>31</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>AUG. 9, 1964</b>              |   |  |  |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>JACKSON MI.</b>   |  | Usual Residence of Decedent   |   |  |  |   |   |  |  |  |
| <b>To Be Completed by Funeral Director</b>   | 10a. State<br><b>MD.</b>   |  | 10b. County<br><b>N/A</b>   |   | 10c. City, Town or Location<br><b>BALTIMORE</b>  |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No        |  |  |  |
|  | 10e. Street and Number<br><b>3507 GARRISON BLVD.</b>   |  |   |   | 10f. Zip Code<br><b>21215</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                          |   |  |  |  |
|  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b> |   |  |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>5+</b>   |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>AGENT</b>  |  | 16b. Kind of Business/Industry<br><b>INSURANCE</b>                      |   |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>MACIE O. TILLMAN SR.</b>   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ENOR TAYLOR</b>  |  |   |   |  |  |  |
| <b>To Be Completed by Physician/Medical Examiner</b>   | 19a. Informant's Name/Relationship (Type, Print)<br><b>MACIE O. TILLMAN SR.</b>  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3507 GARRISON BLVD. BALTO., MD. 21215</b>  |  |   |   |  |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>WOODLAND CEM.</b>  |   | Date<br><b>FEB. 17, 1996</b>   |  | 20c. Location - City or Town, State<br><b>JACKSON MI.</b>               |   |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br>  |  |   |   | 22. Name and Address of Facility<br><b>SKARDA F.H. 2829 HUDSON ST. BALTO., MD. 21224</b>   |  |   |   |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>ASTHMA</b><br>Due to (or as a consequence of):<br><br>b. _____<br>Due to (or as a consequence of):<br><br>c. _____<br>Due to (or as a consequence of):<br><br>d. _____<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |   |   |  |  |   |   | Approximate Interval Between Onset and Death   |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |  |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |  |
|  |  |  |   |   |  |  |   | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  |  |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>        |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                      |  | 28d. Describe how injury occurred  |  |
|  |  |  |   | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                          |  |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |   |  |  |   |   |  |  |  |
| 29b. Signature and title of certifier<br>   |  |  |   |   |  | 29c. License number<br><b>O.C.M.E.</b> |   |   | 29d. Date signed (Month, Day, Year)<br><b>FEB. 10, 1996</b>  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>AARON LOCKE MD 111 Penn Street, Baltimore, Maryland 21201</b>   |  |  |   |   |  |  |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 23 1996</b>  |  |  |   | 32. Registrar's Signature<br>  |  |  |   |   |  |  |  |

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 96 04640

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Julius Griffin Jr.

2. Date of Death  
Month Day Year  
February 17, 1996  
3. Time of Death  
1:30p

4a. Facility Name (If not institution, give street and number)

708 Beaumont Ave.

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

189-09-1235

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
04-06-1919

9. Birthplace (State or Foreign Country)

Georgia

Usual Residence of Decedent

10a. State

Md.

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

302 E. 28 th St.

10f. Zip Code

21218

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married  
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

☒ Yes ☐ No  
If Yes, Give Year or Dates: 5-14-45  
7-13-46

13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8 th

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Mechanic

16b. Kind of Business/Industry

Auto Repair

17. Father's Name (First, Middle, Last)

Julius Griffin Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Essie Gates

19a. Informant's Name/Relationship (Type, Print)

Janet Griffin

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

302 E. 28 th St. Balto., Md. 21218

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Garrison Forrest Vet. 2-23-96 Owings Mills Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

Cable Funeral Service  
5502 Winner Ave. Balto., Md. 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.

Immediate Cause (Final  
disease or condition  
resulting in death)

a. *Stroke*  
Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

*weeks*

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. *Hypertension*  
Due to (or as a consequence of):

*years*

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy  
performed?

☐ Yes ☒ No

24b. Were autopsy findings  
available prior to  
completion of cause  
of death?

☐ Yes ☒ No

25. Was case referred to medical  
examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☐ Natural ☐ Pending  
Investigation  
☐ Accident ☐ Could not be  
determined  
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

29a. Certifier  
(Check only  
one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

*Howard Steiner*

29c. License number

D 38403

29d. Date signed (Month, Day, Year)

FEB-21-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Howard Steiner 5601 Loch Raven Blvd Balto 21239

31. Date filed (Month, Day, Year)

FEB 23 1996

32. Registrar's Signature

*John H. ...*

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

01776 25

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04641

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ELIZABETH ELEANOR JONES</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>Feb</b> DAY <b>21</b> YEAR <b>1996</b>  |  | 3. TIME OF DEATH<br><b>5:43 pm</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>179-14-0839</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>75</b> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>July 10, 1920</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Pennsylvania</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Saint Joseph Medical Center</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Towson, Maryland</b>   |  |
| 9c. COUNTY OF DEATH<br><b>Baltimore</b>  |  |  |  | 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Baltimore</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>502 Old Home Road</b>   |  |
| 10f. ZIP CODE<br><b>21206</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>12th grade</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Supervisor of Contracts</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Advertising Company</b>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William J. Niemeyer</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Elizabeth Thomas</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print) (daughter)<br><b>Mrs. Elizabeth A. Kenney</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>437 Old Home Road, Baltimore, MD 21206</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Parkwood Cemetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>2/24 Baltimore, Maryland</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Schimunek Funeral Homes, Inc.<br/>9705 Belair Rd., Baltimore, MD 21236</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>RESPIRATORY FAILURE</b>   |  |  |  |  |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |  |
| b. <b>CEREBROVASCULAR ACCIDENT</b>   |  |  |  |  |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |  |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |  |  |
| <b>CORONARY ARTERY DISEASE</b>   |  |  |  |  |  |  |  |
| <b>CORONARY ARTERY BYPASS GRAFT</b>  |  |  |  |  |  |  |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>  |  |  |  | 29c. LICENSE NUMBER<br><b>D30448</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>2/22/96</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>PETER J. HORNEFFER, M.D., 7620 YORK ROAD TOWSON, MARYLAND 21204</b>  |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 23 1996</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Page 20





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 96 04642  
Date of Death: February 19, 1996  
Time of Death: 9:45 AM

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Thaddeus Just

2. Date of Death

February 19, 1996

3. Time of Death

9:45 AM

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Bayview Medical Ctr.

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

5. Social Security Number

217-07-2238

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

80

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 29, 1916

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8127 Mid Haven Road

10f. Zip Code

21222

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
6 Years

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

State Highway Administration

16b. Kind of Business/Industry

Highway Admin.

17. Father's Name (First, Middle, Last)

Alexander Just

18. Mother's Name (First, Middle, Maiden Surname)

Theofilina Iwanowicz

19a. Informant's Name/Relationship (Type, Print)

Theresa Just

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8127 Mid Haven Road Dundalk, Maryland 21222

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Meadowridge Mem. Ph. 2/22/1996

Date

20c. Location - City or Town, State

Dorsey, Maryland

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.  
7922 Wise Ave. Dundalk, Maryland 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cerebrovascular Accident

Due to (or as a consequence of):

4 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Chronic Atrial Fibrillation

Due to (or as a consequence of):

1+ year

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Emphysema

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Jodd F. Cox, MD

29c. License number

JHBMC-96015

29d. Date signed (Month, Day, Year)

February 19, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Johns Hopkins Bayview Medical Center, Eastern Avenue, Baltimore, MD

31. Date filed (Month, Day, Year)

FEB 23 1996

32. Registrar's Signature

*[Signature]*

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

2/12/78

Dear Sir,

I am writing to you regarding the matter of the

contract which was entered into between us and your

company on the 1st of January 1978.

I am sorry to hear that you are having

difficulties in fulfilling the contract.

I am sure that you will do your best to

complete the contract as soon as possible.

I am sure that you will be able to

complete the contract by the 1st of March 1978.

I am sure that you will be able to

complete the contract by the 1st of March 1978.

I am sure that you will be able to

complete the contract by the 1st of March 1978.

I am sure that you will be able to

complete the contract by the 1st of March 1978.

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I am sure that you will be able to

complete the contract by the 1st of March 1978.

I am sure that you will be able to

complete the contract by the 1st of March 1978.

I am sure that you will be able to

complete the contract by the 1st of March 1978.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 96 04643  
3. Time of Death 1:46 AM

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) PATRICIA LOUISE JOHNSON  
2. Date of Death Month FEBRUARY Day 22 Year 1996

Funeral  
Director

4a. Facility Name (If not institution, give street and number) HARBOR HOSPITAL CENTER  
4b. City, Town, or Location of Death BALTIMORE  
4c. County of Death N/A

5. Social Security Number 214-56-4886  
6. Sex ☐ M ☒ F  
7. Age (In yrs. last birthday) 44 Yrs.  
8. Date of Birth (Month, Day, Year) June 15 1951  
9. Birthplace (State or Foreign Country) Va.

Usual Residence of Decedent  
10e. State Md  
10b. County N/A  
10c. City, Town or Location Baltimore  
10d. Inside City Limits ☒ Yes ☐ No

10e. Street and Number 2415 Seamon Ave.  
10f. Zip Code 21225  
10g. Citizen of What Country? USA

11. Marital Status  
1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced  
12. Was Decedent Ever in U.S. Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:  
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:  
14. Race - American Indian, Black, White, etc.  
Specify: Black

15. Decedent's Education (Specify only highest grade completed)  
Elementary/Secondary (0-12) 10 College (1-4 or 5+)  
16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housekeeper  
16b. Kind of Business/Industry Hotel

17. Father's Name (First, Middle, Last) Willie A. Gilbert  
18. Mother's Name (First, Middle, Maiden Surname) Lorraine Shipman

19a. Informant's Name/Relationship (Type, Print) Kelvin Johnson  
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2415 Seamon Ave. Balto. Md. 21225

20e. Method of Disposition  
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)  
20b. Place of Disposition (Name of cemetery, crematory or other place) M.T. Zion  
20c. Location - City or Town, State 2121 Baltimore Md.

21. Signature of Funeral Service Licensee James A. Morton  
22. Name and Address of Facility James A. Morton & Sons 1701 Laurens St. Balto. Md. 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  
Immediate Cause (Final disease or condition resulting in death)  
e. ENCEPHALOPATHY  
Due to (or as a consequence of):  
b. MALIGNANT HYPERTENSION  
Due to (or as a consequence of):  
c. UNCONTROLLED HYPERTENSION  
Due to (or as a consequence of):  
d.   
Approximate Interval Between Onset and Death 2 days  
2 days  
16 years

23b. Did tobacco use contribute to the cause of death?  
1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown  
24e. Was an autopsy performed? 1 ☒ Yes 2 ☐ No  
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  
25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No  
26. Place of Death (Check only one)  
Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)  
27. Manner of Death  
1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide  
28e. Date of Injury (Month, Day, Year)  
28b. Time of Injury M  
28c. Injury at Work? 1 ☐ Yes 2 ☐ No  
28d. Describe how injury occurred  
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier K. Ambalavanar House STAFF  
29c. License number AS2441614-16  
29d. Date signed (Month, Day, Year) February 22nd 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print) K. AMBALAVANAR - HARBOR HOSPITAL CENTER 3001 SOUTH HANOVER STREET

31. Date filed (Month, Day, Year) FEB 23 1996  
32. Registrar's Signature John P. ...

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 96 04644

|   |  |   |  |  |   |  |   |  |
|---|--|---|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>HARRIS REBECCA JONES</b>                  |   |  |  | 2. Date of Death<br>Month Day Year<br><b>FEBRUARY 14 1996</b>       |  | 3. Time of Death<br><b>3:10 PM</b>                      |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Harbor Hospital</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Cherry Hill Maryland</b> |  | 4c. County of Death<br><b>Baltimore</b>                 |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>212-20-0449</b>  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>78</b> Yrs.                    |  | 8. Date of Birth (Month, Day, Year)<br><b>2 24 1917</b> |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>North Carolina</b>                        |   | 10a. State<br><b>Md.</b>   |  | 10b. County<br><b>N/A</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>         |  |
| 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>2728 Carver Road</b>   |  | 10f. Zip Code<br><b>21225</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>  |   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>              |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12 th</b><br>College (1-4 or 5+) <b>2 yrs.</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Foster Parent</b>                     |  | 16b. Kind of Business/Industry<br><b>Correctional Facility</b>   |   |  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Will Price</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Summa)<br><b>Rhen Price</b>   |   |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Morris E. Jones</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2914 Southland Ave. Balto., Md. 21225</b>  |   |  |   |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mt. Zion Cemetery</b>  |  | 20c. Location - City or Town, State<br><b>2-20-96 Landsdowne, Md.</b>  |   |  |   |  |
| 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>Caple Funeral Service</b><br><b>5502 Winner Ave. Balto., Md. 21215</b>  |   |  |   |  |
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. LUNG CANCER WITH METASTASIS</b><br>Due to (or as a consequence of):<br><br><b>b.</b><br>Due to (or as a consequence of):<br><br><b>c.</b><br>Due to (or as a consequence of):<br><br><b>d.</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |   |  |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |   |  |  |   |  |   |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |  |   |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |  |  |   |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |   |  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |  |   |  |   |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |   |  |  |   |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   |  |
|   |  | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)         |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.  |  |   |  |  |   |  |   |  |
| 29b. Signature and title of certifier<br>   |  |   |  | 29c. License number<br><b>AS2441614-67</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>FEBRUARY 14, 1996</b>                      |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>BUTCH B. TUBERA HARBOR HOSPITAL CENTER BALTIMORE, MARYLAND 21228</b>   |  |   |  |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 23 1996</b>   |  |   |  |  |   |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1000 1000

20

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 96 04645

|   |   |  |   |  |   |  |   |  |   |  |
|---|---|--|---|--|---|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>Jesse F. Kaler, Jr.   |  |   |  |   |  | 2. Date of Death<br>Month Day Year<br>FEBRUARY 15, 1996   |  | 3. Time of Death<br>9:00 AM   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>202 Stonewall Road  |  |   |  |   |  | 4b. City, Town, or Location of Death<br>Catonsville   |  | 4c. County of Death<br>Baltimore  |  |
| Funeral<br>Director                           | 5. Social Security Number<br>216-01-4556  |  | 8. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>76 Yrs.   |  | If Under 1 Year<br>Months Days  |  | If Under 24 Hrs.<br>Hours Min.  |  |
|   | 6. Date of Birth (Month, Day, Year)<br>MAR. 11, 1919  |  | 9. Birthplace (State or Foreign Country)<br>Maryland  |  | 10. Usual Residence of Decedent<br>10a. State: Md. 10b. County: Howard 10c. City, Town or Location: Elkridge 10d. Inside City Limits: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 11. Street and Number<br>6259 Old Washington Rd.  |  | 12. Zip Code<br>21227   |  |
| To Be Completed by Funeral Director           | 13. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |  | 14. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1942-1945  |  | 15. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  | 16. Race - American Indian, Black, White, etc.<br>Specify: white  |  | 17. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12): 12 College (1-4 or 5+): N/A                           |  |
|   | 18. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Assistant Purchasing Agent  |  | 19. Kind of Business/Industry<br>Henry J. Knott   |  | 20. Father's Name (First, Middle, Last)<br>Jesse F. Kaler, Sr.  |  | 21. Mother's Name (First, Middle, Maiden Surname)<br>Elsie Bossert  |  | 22. Informant's Name/Relationship (Type, Print)<br>Bonnie K. Poligardo  |  |
| Physician<br>/Medical<br>Examiner             | 23. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 24. Place of Disposition (Name of cemetery, crematory or other place)<br>The Green Mount Cemetery   |  | 25. Date<br>2/19/96   |  | 26. Location - City or Town, State<br>Baltimore, Maryland   |  | 27. Signature of Funeral Service Licensee<br>Gary L. Kaufman Funeral Home of Elkridge, Inc.<br>5695 Main St., Elkridge, Md. 21227                     |  |
|   | 28. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.<br>Immediate Cause (Final disease or condition resulting in death)<br>Congestive Heart Failure<br>Due to (or as a consequence of):<br>Coronary Artery Disease<br>Due to (or as a consequence of):<br>Due to (or as a consequence of):<br>Due to (or as a consequence of): |  | 29. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Rural Failure   |  | 30. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  | 31. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 32. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
| To Be Completed by Physician/Medical Examiner | 33. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 34. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 35. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |  | 36. Date of Injury (Month, Day, Year)<br>28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 37. Time of Injury<br>M   |  |
|   | 38. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 39. Describe how injury occurred  |  | 40. Location (Street and Number or Rural Route Number, City or Town, State)   |  | 41. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 42. Signature and title of certifier<br>Stephen Plouthall MD  |  |
| State Registrar                               | 43. License number<br>D23580  |  | 44. Date signed (Month, Day, Year)<br>2/22/96   |  | 45. Name and address of person who completed cause of death (Item 23a) (Type, Print)  |  | 46. Date filed (Month, Day, Year)<br>FEB 23 1996  |  | 47. Registrar's Signature<br>L. H. [Signature]  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: And this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. DECEDENT'S NAME (First, Middle, Last)  |  |  |                                | 2. DATE OF DEATH  |  |  |  | 3. TIME OF DEATH  |  |
|---|--|--|--------------------------------|---|--|--|--|---|--|
| NAOMI A. KRAM   |  |  |                                | FEB. 17, 1996   |  |  |  | 12:50 A.M.  |  |
| 4. SOCIAL SECURITY NUMBER   |  | 5. SEX   | 6. AGE (In yrs. last birthday) | 7. DATE OF BIRTH  |  | 8. BIRTHPLACE (State or Foreign Country)                                     |  |   |  |
| 212-07-7603   |  | 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F               | 85 YRS.                        | AUG. 18, 1910   |  | MD.  |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)  |  |  |                                | 9b. CITY, TOWN OR LOCATION OF DEATH   |  |  |  | 9c. COUNTY OF DEATH   |  |
| LORIAN NURSING HOME   |  |  |                                | BALTIMORE   |  |  |  | N/A   |  |
| RESIDENCE OF DECEDENT   |  |  |                                |   |  |  |  |   |  |
| 10a. STATE  |  | 10b. COUNTY  |                                | 10c. CITY, TOWN OR LOCATION   |  |  |  | 10d. INSIDE CITY LIMITS?  |  |
| MD.   |  | N/A  |                                | BALTIMORE   |  |  |  | 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER  |  |  |                                | 10f. ZIP CODE   |  | 10g. CITIZEN OF WHAT COUNTRY?  |  |   |  |
| 2811 HUDSON ST.   |  |  |                                | 21224   |  | U.S.A.   |  |   |  |
| 11. MARITAL STATUS  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?  |                                | 13. WAS DECEDENT OF HISPANIC ORIGIN?  |  |  |  | 14. RACE — American Indian, Black, White, etc.                          |  |
| 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married   |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO            |                                | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | Specify: WHITE  |  |
| 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | IF YES, GIVE WAR OR DATES  |                                | Specify:  |  |  |  |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)   |  |  |                                | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |
| Elementary/Secondary (0-12) 8   |  |  |                                | College (1-4 or 5+) HOMEMAKER   |  |  |  | OWN HOME  |  |
| 17. FATHER'S NAME (First, Middle, Last)   |  |  |                                | 18. MOTHER'S NAME (First, Middle, Maiden Surname)   |  |  |  |   |  |
| THOMAS ARTHUR   |  |  |                                | MARGARET UNKNOWN  |  |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)  |  |  |                                | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)   |  |  |  |   |  |
| GERARD KRAM   |  |  |                                | 2336 HAMILTOWN CIRCLE BALTO, MD. 21237  |  |  |  |   |  |
| 20a. METHOD OF DISPOSITION  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, or other place) |                                | DATE  |  | 20c. LOCATION — City or Town, State  |  |   |  |
| 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State   |  | MOST HOLY REDEEMER FEB 20, 96  |                                | BALTO., MD.   |  |  |  |   |  |
| 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |                                |   |  |  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE   |  |  |                                | 22. NAME AND ADDRESS OF FACILITY  |  |  |  |   |  |
| Thomas J. Skarda Jr.  |  |  |                                | SKARDA F.H. 2829 HUDSON ST. BALTO., MD. 21224   |  |  |  |   |  |
| 23. PART I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |  |                                |   |  |  |  | Approximate Interval Between Onset and Death                            |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →   |  |  |                                |   |  |  |  | 15 MONTHS   |  |
| a. Metastatic Colon Cancer to Liver   |  |  |                                |   |  |  |  |   |  |
| b. Lungs + Bone   |  |  |                                |   |  |  |  |   |  |
| Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  |  |  |                                |   |  |  |  |   |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):   |  |  |                                |   |  |  |  |   |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):   |  |  |                                |   |  |  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |                                |   |  |  |  |   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |                                |   |  |  |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?  |  |  |                                | 26. PLACE OF DEATH (Check only one)   |  |  |  |   |  |
| 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |                                | HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |   |  |
| 27. MANNER OF DEATH   |  |  |                                | 28a. DATE OF INJURY   |  | 28b. TIME OF INJURY  |  | 28c. INJURY AT WORK?  |  |
| 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |  |  |                                | 28a. DATE OF INJURY   |  | 28b. TIME OF INJURY  |  | 28c. INJURY AT WORK?  |  |
|   |  |  |                                |   |  |  |  |   |  |
|   |  |  |                                | 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  |   |  |
|   |  |  |                                |   |  |  |  |   |  |
|   |  |  |                                | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |  |   |  |
|   |  |  |                                |   |  |  |  |   |  |
| 29a. CERTIFIER (Check only one)   |  |  |                                |   |  |  |  |   |  |
| 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |                                |   |  |  |  |   |  |
| 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                |  |  |                                |   |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER   |  |  |                                | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)  |  |   |  |
| Fredric S. Sirkis M.D.  |  |  |                                | D22645  |  | 2/19/96  |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)   |  |  |                                |   |  |  |  |   |  |
| FREDRIC S. Sirkis M.D. 7151 HOLABIRD AVE. BALTO. MD. 21222  |  |  |                                |   |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)   |  |  |                                | 32. REGISTRAR'S SIGNATURE   |  |  |  |   |  |
| FEB 23 1996   |  |  |                                | John Davidson-Rodell  |  |  |  |   |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 96 04647

|   |  |   |   |  |  |  |  |   |
|---|--|---|---|--|--|--|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Demetris Kishis</b>   |   |   |  | 2. Date of Death<br>Month Day Year<br><b>February 21, 1996</b>   |  | 3. Time of Death<br><b>8:00am</b>  |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>North Arundel Hospital 301 Hospital Dr Glen Burnie</b>  |   |   |  | 4b. City, Town, or Location of Death<br><b>Anne Arundel</b>  |  | 4c. County of Death<br><b>Anne Arundel</b>   |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>214-82-6652</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>61</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Oct. 16, 1934</b>                                    | 9. Birthplace (State or Foreign Country)<br><b>Cyprus</b> |
|   | Usual Residence of Decedent  |   |   |  |  |  |  |   |
| To Be Completed by Funeral Director   | 10a. State<br><b>MD</b>  | 10b. County<br><b>Anne Arundel</b>  |   | 10c. City, Town or Location<br><b>Annapolis</b>  |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |
|   | 10e. Street and Number<br><b>112 Kuethe Drive</b>  |   |   | 10f. Zip Code<br><b>21403</b>                    |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |   |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |   |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Cobbler</b>                           |  |  | 16b. Kind of Business/Industry<br><b>Shoe</b>  |  |   |
|   | 17. Father's Name (First, Middle, Last)<br><b>Christos Kishis</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Chrystalla</b>   |  |  |   |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Androulla C. Kishis</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>112 Kuethe Drive, Annapolis, MD 21403</b>  |  |  |   |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>St. Constantine &amp; Helen 7/24</b>                                     |  | 20c. Location - City or Town, State<br><b>Annapolis, MD</b>  |  |  |   |
|   | 21. Signature of Funeral Service Licensee<br>  |   |   |  | 22. Name and Address of Facility<br><b>Hardesty Funeral Home, P.A.<br/>12 Ridgely Ave. Annapolis MD 21401</b>  |  |  |   |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>HEPATIC FAILURE</b><br>Due to (or as a consequence of):<br><b>METASTATIC COLON CANCER</b><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Approximate Interval Between Onset and Death<br><b>3 weeks</b> |   |   |  |  |  |  |   |
|   | 23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):                               |   |   |  |  |  |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |   |
|   |  |   |   |  |  | 24e. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |
|   |  |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |  |  |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicidal 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M                         |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28d. Describe how Injury occurred                |  |  |  |   |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br>MD.  |   | 29c. License number<br><b>D43977</b>             |  | 29d. Date signed (Month, Day, Year)<br><b>February 21 1996</b>   |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ANNA DREYER, 301 HOSP. DRIVE, GLEN BURNIE MD 21061.</b>  |  |   |   |  |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>FEB 23 1996</b>   |  |   |   |  |  |  |  |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Page 2

The first part of the report deals with the general situation of the country. It is a very interesting and informative study of the country's development. The second part of the report deals with the specific details of the country's development. It is a very detailed and thorough study of the country's development. The third part of the report deals with the specific details of the country's development. It is a very detailed and thorough study of the country's development.

The report is a very interesting and informative study of the country's development. It is a very detailed and thorough study of the country's development. The report is a very interesting and informative study of the country's development. It is a very detailed and thorough study of the country's development.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 96 04648

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Frank Korom

2. Date of Death

Feb. 18, 1996

3. Time of Death

2340

4a. Facility Name (If not institution, give street and number)

493 Saltoun Road

4b. City, Town, or Location of Death

Odenton

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

324-24-5792

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

62

8. Date of Birth

Feb. 20, 1933

9. Birthplace (State or Foreign Country)

Illinois

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Odenton

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

493 Saltoun Road

10f. Zip Code

21113

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (14 or 5+)

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Enlisted

16b. Kind of Business/Industry

US Army

17. Father's Name (First, Middle, Last)

John Grizzle

18. Mother's Name (First, Middle, Maiden Surname)

Mary

19a. Informant's Name/Relationship (Type, Print)

Yoshiko Korom

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

493 Saltoun Road, Odenton, MD 21113

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland Veterans Cem.

Date

2/21/96

20c. Location - City or Town, State

Crownsville, MD

21. Signature of Funeral Service Licensee

*Robert J. Grizzle*

22. Name and Address of Facility

Hardesty Funeral Home, P.A.  
12 Ridgely Ave. Annapolis, MD 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Cardiac Failure

Due to (or as a consequence of):

b. Hypertensive Heart Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*William P. Jones, MD Deputy*

29c. License number

D 06054

29d. Date signed (Month, Day, Year)

Feb 20 96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William P. Jones, MD 645 America Ct. 21035

31. Date filed (Month, Day, Year)

FEB 23 1996

32. Registrar's Signature

*John A. Randall*

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

0123456789

10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 96 04649

ITEM 19a, Item 6, 20c, Film 732, 2/23/96

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State Registrar

Physician / Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br>DONALD E. KING Jr.  |  |   |  | 2. Date of Death<br>Month Day Year<br>FEBRUARY 20, 1996  |  | 3. Time of Death<br>8:45 AM  |  |
| 4a. Facility Name (If not institution, give street and number)<br>THE JOHNS HOPKINS HOSPITAL  |  |   |  | 4b. City, Town, or Location of Death<br>BALTIMORE CITY   |  | 4c. County of Death<br>n/a   |  |
| 5. Social Security Number<br>212-25-4373  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>7 Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br>FEB. 27, 1988   |  |
| 9. Birthplace (State or Foreign Country)<br>BALTIMORE, MD   |  | 10a. State<br>MD  |  | 10b. County<br>n/a   |  | 10c. City, Town or Location<br>BALTIMORE   |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br>1909 OAKHILL AVENUE   |  | 10f. Zip Code<br>21218   |  | 10g. Citizen of What Country?<br>UNITED STATES   |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: BLACK   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 2nd<br>College (1-4or 5+) -  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>STUDENT STUDENT  |  | 16b. Kind of Business/Industry<br>PRIMARY GRADE SCH.   |  |  |  |
| 17. Father's Name (First, Middle, Last)<br>DONALD KING SR.  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>VALERIE FOUNTAIN  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><del>717</del> DONALD KING SR.  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) apt. 912<br>717 DRUID PARK LAKE DRIVE, BALTIMORE, MD 21217                                     |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>WOODLAWN CEMETERY   |  | 20c. Location - City or Town, State<br>BALTIMORE   |  | 20d. Date<br>2-24  |  |
| 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br>WM. C. MARCH FH.-1101 E. NORTH AVENUE  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. BRAINSTEM HERNIATION<br>Due to (or as a consequence of):<br>b. MALIGNANT BRAINTUMOR (PONTINE GLIOMA)<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |  |  |  |
| Approximate Interval Between Onset and Death<br>~24 hrs.<br>8 mos.  |  |   |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>NONE  |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
|   |  |   |  |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
|   |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28d. Describe how injury occurred  |  |  |  |
| 28e. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |  |  |  |  |
| 29b. Signature and title of certifier<br>Sheri L. Spurr MD Clinical Fellow Pediatric Oncology   |  | 29c. License number<br>D47504   |  | 29d. Date signed (Month, Day, Year)<br>FEBRUARY 20th, 1996   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>600 N. Wolfe Street, CMSC 800, Baltimore MD 21287   |  |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>FEB 23 1996  |  |   |  | 32. Registrar's Signature<br>  |  |  |  |

Page 71

The first of these is the fact that the system is not a simple one.

It is a complex one.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item 1, 20b, Film 732, 2/23/96, 1t

## Certificate of Death

Reg. No. 96 04650

|  |  |  |   |                                      |   |   |   |   |  |  |
|--|--|--|---|--------------------------------------|---|---|---|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><i>Gertrude Edna Loney</i>   |  |   |                                      |   |   | 2. Date of Death<br>Month Day Year<br><i>Feb. 15, 1996</i>            |   | 3. Time of Death<br><i>9:30 A.M.</i>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><i>3030 Hudson Street</i>  |  |   |                                      |   |   | 4b. City, Town, or Location of Death<br><i>Baltimore</i>              |   | 4c. County of Death<br><i>N/A</i>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><i>156-05-5891</i>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |                                      | 7. Age (In yrs. last birthday)<br><i>76</i> Yrs.  |   | 8. Date of Birth (Month, Day, Year)<br><i>Oct. 8, 1919</i>            |   | 9. Birthplace (State or Foreign Country)<br><i>New Jersey</i>                                  |  |
|  | Usual Residence of Decedent  |  |   |                                      |   |   |   |   |  |  |
| To Be Completed by Funeral Director  | 10a. State<br><i>Maryland</i>  |  | 10b. County<br><i>N/A</i>   |                                      | 10c. City, Town or Location<br><i>Baltimore</i>   |   |   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
|  | 10e. Street and Number<br><i>3030 Hudson Street</i>  |  |   |                                      | 10f. Zip Code<br><i>21224</i>   |   | 10g. Citizen of What Country?<br><i>U.S.A.</i>                        |   |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                      | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>White</i> |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br><i>12th grade</i>   |  |   |                                      | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>Mail Room Clerk</i>   |   |   | 16b. Kind of Business/Industry<br><i>Credit Company</i>                 |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><i>Charles Kimball</i>  |  |   |                                      |   |   | 18. Mother's Name (First, Middle, Maiden Summa)<br><i>Albra Drury</i> |   |  |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br><i>Leslie P. Loney (Son)</i>   |  |   |                                      | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>3030 Hudson Street, Baltimore, Maryland 21224</i>   |   |   |   |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Dulaney Valley Cemetery</i>  |                                      | 20c. Location - City or Town, State<br><i>Timonium, Maryland</i>  |   | 20d. Date<br><i>2/19</i>  |   |  |  |
|  | 21. Signature of Funeral Service Licensee<br><i>Robert J. Prodan</i>   |  |   |                                      | 22. Name and Address of Facility<br><i>Schimunek Funeral Home<br/>3331 Brehms Lane, Baltimore, Maryland 21213</i>   |   |   |   |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><i>a. ACUTE HEPATIC FAILURE</i><br>Due to (or as a consequence of):<br><i>b. BILIARY CIRRHOSIS</i><br>Due to (or as a consequence of):<br><i>c. SCLEROSING CHOLANGITIS</i><br>Due to (or as a consequence of):<br><i>d. ONE YEAR</i> |  |   |                                      |   |   |   |   |  |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |                                      |   |   |   |   |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   |                                      |   |   |   |   |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |   |                                      |   |   |   |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   |                                      |   |   |   |   |  |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |  |   |                                      |   |   |   |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)                                     |   | 28b. Time of Injury<br><i>M</i>      |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   | 28d. Describe how injury occurred                                       |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><i>Joseph D. Notarangelo M.D.</i> |   | 29c. License number<br><i>D07316</i> |   | 29d. Date signed (Month, Day, Year)<br><i>FEBRUARY 16-1996</i>                              |   |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>JOSEPH D. NOTARANGELO M.D. 301 ST. PAUL PLACE BALTIMORE 21202</i>   |  |  |   |                                      |   |   |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><i>FEB 23 1996</i>  |  | 32. Registrar's Signature<br><i>Don-Pendall</i>                            |   |                                      |   |   |   |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar


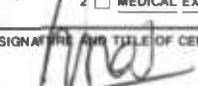



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04651

|   |  |  |  |   |  |   |  |   |  |  |  |
|---|--|--|--|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>JOHN JAMES LANGREHR</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>2</b> DAY <b>20</b> YEAR <b>1996</b>   |  |   |  | 3. TIME OF DEATH<br><b>5<sup>10</sup> P<sup>M</sup></b>   |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>219-18-9569</b>   |  | 5. SEX<br><b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>72</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Aug. 12, 1923</b>                                 |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>   |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Fallston General Hospital</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Fallston</b>  |  |   |  | 9c. COUNTY OF DEATH<br><b>Harford</b>   |  |  |  |
| 10a. STATE<br><b>Maryland</b>   |  |  |  | 10b. COUNTY<br><b>Harford</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Fallston</b>  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO       |  |  |  |
| 10e. STREET AND NUMBER<br><b>102 Fidelity Drive</b>   |  |  |  | 10f. ZIP CODE<br><b>21047</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WW II</b>   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                     |  |   |  |  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b><br><b>12th grade</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Owner</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Heating &amp; Air Conditioning Company</b>             |  |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>John W. Langrehr</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Anna Riebold</b>  |  |   |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mrs. Myrtle Langrehr (wife)</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>102 Fidelity Drive, Fallston, MD 21047</b>  |  |   |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Parkwood Cemetery</b>  |  | DATE<br><b>2/24</b>   |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, Maryland</b>                           |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Schimunek Funeral Homes, Inc.</b><br><b>9705 Belair Rd., Baltimore, MD 21236</b>   |  |   |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>End Stage Respiratory failure</b><br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST {<br>a. DUE TO (OR AS A CONSEQUENCE OF): <b>Severe Chronic obstructive Pulm Disease</b><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Ventricular fibrillation, Anoxic encephalopathy</b><br><br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> |  |  |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |   |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br> <b>Attending</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D-16444</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>Feb 20 1996</b>                                   |  |   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>V.S. NAIRM.D. 2112 Belair Road. Fallstar MD 21047</b>   |  |  |  |   |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 23 1996</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>  |  |   |  |   |  |  |  |

12+1

12200 72

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04652

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

|  |  |  |  |  |  |  |  |  |  |   |  |   |  |
|--|--|--|--|--|--|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>CHARLES</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>FEBRUARY 21 1996</b>  |  |  |  | 3. TIME OF DEATH<br><b>3:29 PM</b>   |  |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>215-14-0937</b>  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>71</b> YRS.   |  | 7. DATE OF BIRTH<br>Month, Day, Year<br><b>April 28, 1924</b>                        |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>  |  |   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Good Samaritan Hospital</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>  |  |  |  | 9c. COUNTY OF DEATH<br><b>N/A</b>  |  |   |  |   |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>N/A</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO        |  |   |  |   |  |
| 10e. STREET AND NUMBER<br><b>1027 Cathedral St. 16-D</b>   |  |  |  | 10f. ZIP CODE<br><b>21201</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |  |  |   |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WWII</b>  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yea or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Afro-American</b>   |  |  |  |   |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Steel Worker</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Steel Company</b>                               |  |  |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Flenora Lewis</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Beunnie Wright</b>   |  |  |  |  |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Daisy C. Lewis</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>623 Main St. Balto. Md. 21222</b>  |  |  |  |  |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Garrison Forest</b>  |  | DATE<br><b>2/21/96</b>   |  | 20c. LOCATION — City or Town, State<br><b>2444 Owings Mills, Md.</b>                 |  |  |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Joseph L. Rust</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Joseph L. RUSSELL F/H<br/>2222 W. 1612th Ave. 21216</b>   |  |  |  |  |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>pneumonia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST {<br>a. <b>lung cancer</b> DUE TO (OR AS A CONSEQUENCE OF):<br>c. <b>Vasculitis</b> DUE TO (OR AS A CONSEQUENCE OF):<br>d. <b>polymyositis</b><br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>chronic systemic corticosteroids</b><br><br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> |  |  |  |  |  |  |  | Approximate Interval Between Onset and Death<br><b>1 wk</b><br><b>weeks</b><br><b>yrs</b><br><b>17 yrs</b> |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |  |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  |   |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |  |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Ali Moussa, M.D.</b>   |  | 29c. LICENSE NUMBER<br><b>P09301</b>            |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>February 21, 1996</b> |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>ALI MOUSSA Good Samaritan Hospital 5601 Loch Raven Blvd Baltimore, MD 21239</b>  |  |  |  |  |  |  |  | 31. DATE FILED (Month, Day, Year)<br><b>FEB 23 1996</b>  |  | 32. REGISTRAR'S SIGNATURE<br><b>John M. ...</b> |  |   |  |

56

96-809-031

96-037 ITEM: 3. PER MED

B.K.S FILM 6-734 4/18/96 t.t

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04653

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

TOM THOMAS CHALMERS

LOATMAN

2. Date of Death

Month Day Year  
FEB. 16, 19963. Time of Death  
5:40 PM

4a. Facility Name (If not institution, give street and number)

1900 LYTONSVILLE ROAD

4b. City, Town, or Location of Death

SILVER SPRING

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

223-33-5150

6. Sex

M 2 ☒ F

7. Age (In yrs. last birthday)

23 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
May 18, 1972

9. Birthplace (State or Foreign Country)

New York, NY

Usual Residence of Decedent

10a. State

Virginia

10b. County

Fairfax

10c. City, Town or Location

Vienna

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9903 Snowbound Court

10f. Zip Code

22181

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12College (14-17)  
016a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Business Trades

16b. Kind of Business/Industry

U.S. Job Corp

17. Father's Name (First, Middle, Last)

R. Bruce Loatman

18. Mother's Name (First, Middle, Maiden Surname)

Carol A. Chalmers

19a. Informant's Name/Relationship (Type, Print)

R. Bruce Loatman / father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11727 Great Owl Cr., Reston, VA 22094

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

National Memorial Park

Date

2/22/96

20c. Location - City or Town, State

Falls Church, VA

21. Signature of Funeral Service Licensee

*J. Berkeley Green*

22. Name and Address of Facility

Green Funeral Home, Inc.  
P.O. Box 385, 721 Elden St., Herndon, VA 2207023a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only the cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. *Smoke and soot inhalation, general body burns*  
Due to (or as a consequence of):Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
Investigation  
2 ☒ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)  
2-16-96

28b. Time of Injury

1740 M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Occupant

28a. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)

Railroad

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)1900 Lytonville Road  
Silver Spring, Montgomery Co.29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician2 ☒ Medical ExaminerTo the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

*Donald G. Wright MD*

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

FEBRUARY 17, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DONALD G. WRIGHT MD

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

FEB 23 1996

32. Registrar's Signature

*J. David Wright*

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

per FH

item#18 film#732 2/23/96 ag

Certificate of Death

Reg. No.

96 04654

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JOHANNA

LEEN

2. Date of Death

Month FEB Day 18 Year 1996

3. Time of Death

1:05 AM

4a. Facility Name (If not institution, give street and number)

FRIENDS NURSING HOME

4b. City, Town, or Location of Death

SANDY SPRING

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

079-20-7299

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

NOV. 13, 1909

9. Birthplace (State or Foreign Country)

IRELAND

Usual Residence of Decedent

10a. State

MD

10b. County

MONTGOMERY

10c. City, Town or Location

SANDY SPRING

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

17340 QUAKER LANE

10f. Zip Code

20860

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married

3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8TH GRADE

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SOLDERER

16b. Kind of Business/Industry

ELECTRONICS

17. Father's Name (First, Middle, Last)

JOHN DEVLIN

18. Mother's Name (First, Middle, Maiden Surname)

MARY O'BRIEN MARY O'BRIEN

19a. Informant's Name/Relationship (Type, Print)

MRS. CHRISITINA GREEN

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5837 WYNDHAM CIRCLE-APT-301-COLUMBIA, MD 21044

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

LONG ISLAND NAT'L CEM.

Date

2/22/96

20c. Location - City or Town, State

PINELAWN, N.Y.

21. Signature of Funeral Service Licensee

*M. Neef Coleman*

22. Name and Address of Facility

HUBBARD FUNERAL HOME, INC.

4107 WILKENS AVENUE-Baltimore, Md 21229

23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

BRONCHOPNEUMONIA

Approximate Interval Between Onset and Death

TERMINAL

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

ADVANCED COPD

d. Due to (or as a consequence of):

15/YRS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CORONARY ARTERY DISEASE

CHF (CARDIOMYOPATHY)

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural

2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

5 ☐ Pending investigation

6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Donald R. Lewis MD*

29c. License number

D06406

29d. Date signed (Month, Day, Year)

FEB. 18, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DONALD R. LEWIS MD

RT108 OLNEY MD 20832

31. Date filed (Month, Day, Year)

FEB 23 1996

32. Registrar's Signature

*John Davidson Randall*

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

1888

Dear Sir,  
I have the honor to acknowledge the receipt of your letter of the 10th inst.

and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

I am, Sir, very respectfully,  
Your obedient servant,  
J. H. [Signature]

[Faint, illegible text]

[Faint, illegible text]

[Faint, illegible text]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Item 27, 28, 31, Film 732, 2/23/96, State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 96 01655  
Date of Death Month FEB Day 1 Year 1996 Time of Death 1435

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Anita S. MOORE

2. Date of Death

Month FEB

Day 1

Year 1996

3. Time of Death

1435

4a. Facility Name (If not institution, give street and number)

St. Agnes Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

215-01-2214

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
May 24, 1918

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Washington, D.C. N/A

10b. County

10c. City, Town or Location

Washington, D.C.

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4074 Mansion Drive N.W.

10f. Zip Code

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2 yrs.

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Life Insurance Co.

17. Father's Name (First, Middle, Last)

Paul M. Siemers, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Marie Quaty Spitznagle

19a. Informant's Name/Relationship (Type, Print)

Joy P. O'Rourke Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4074 Mansion Drive N.W. Washington, D.C. 20007

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Woodlawn Cemetery

Date

Feb. 5, 1996

20c. Location - City or Town, State

Woodlawn, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

1050 York Road

Ruck Towson Funeral Home, Inc. Towson, Md. 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Subdural hemorrhage

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

20 hrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

JAN 31, 1996

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, tectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Myung Hee Nam MD.

29c. License number

D35106

29d. Date signed (Month, Day, Year)

Feb 1, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ST Agnes Hospital,

31. Date filed (Month, Day, Year)

FEB 1, 1996

32. Registrar's Signature

FEB 23 1996

Edison-Randall

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

32246 21

27/11/1954

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11/11/1954

11/11/1954

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 04656

Physician  
/Medical  
Examiner

Funeral  
Director

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
certificate.

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>MARY JANE MCELROY</b>   |  | 2. Date of Death<br>Month <b>FEBRUARY</b> Day <b>18</b> , Year <b>1996</b>  |  | 3. Time of Death<br><b>11:00 AM</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>THE JOHNS HOPKINS HOSPITAL</b>  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE CITY</b>   |  | 4c. County of Death<br><b>BALTIMORE CITY</b>   |  |
| 5. Social Security Number<br><b>333-24-6511</b>  |  | 8. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>64</b> Yrs.   |  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>BALTIMORE</b>   |  | 10c. City, Town or Location<br><b>REISTERSTOWN</b>   |  |
| 10e. Street and Number<br><b>200 NORTHWAY ROAD</b>   |  | 10f. Zip Code<br><b>21136</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b><br><b>12TH GRADE</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>SECRETARY</b>   |  | 16b. Kind of Business/Industry<br><b>STATE OF MARYLAND</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>EDWARD TAYLOR McMURRAY</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ROSA LEE ANDERSON</b>   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>ROBERT L. McELROY</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>200 NORTHWAY ROAD - REISTERSTOWN, MD 21136</b>  |  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>CAVE HILL CEMETERY</b>   |  | 20c. Location - City or Town, State<br><b>LOUISVILLE, KENTUCKY</b>   |  |
| 21. Signature of Funeral Service Licensee<br><i>Jackie D. Shannon</i>  |  | 22. Name and Address of Facility<br><b>HUBBARD FUNERAL HOME, INC.</b><br><b>107 WILKENS AVENUE-BALTIMORE, MD 21229</b>  |  |  |  |
| 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. GRAM NEGATIVE BACTEREMIA/SEPSIS</b><br>Due to (or as a consequence of):<br><b>b. NEUTROPENIA</b><br>Due to (or as a consequence of):<br><b>c. METASTATIC BREAST CARCINOMA</b><br>Due to (or as a consequence of):<br><b>d.</b> |  | Approximate Interval Between Onset and Death<br><b>48 HOURS</b><br><b>5 DAYS</b><br><b>13 YEARS</b>   |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)<br><b>M</b>   |  | 28b. Time of Injury<br><b>1</b> Yes <input type="checkbox"/> No  |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28c. Describe how injury occurred   |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |  |
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. Signature and title of certifier<br><i>Paul J. DeGall, DO</i>  |  | 29c. License number<br><b>AJ2402321 P9945</b>  |  |
| 29d. Data signed (Month, Day, Year)<br><b>FEBRUARY 18, 1996</b>  |  |   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>PAUL J. DEGALL, DO 600 NORTH WOLFE STREET BALTIMORE MARYLAND 21287</b>  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 23 1996</b>  |  |   |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04657

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Genevieve Miller

2. Date of Death

Month Day Year  
February 22 1996

3. Time of Death

10:15 PM

4a. Facility Name (If not institution, give street and number)

HOPKINS - BAY VIEW

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

215-03-5479

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

90 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year  
10-17-05

9. Birthplace (State or Foreign)

POLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

BALTIMORE

10c. City, Town or Location

DUNDALK

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6736 BESSEMER AVENUE

10f. Zip Code

21222

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
6 YEARS

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

STANLEY FRANCZKOWSKI

18. Mother's Name (First, Middle, Maiden Surname)

STEPHANIE KUBINSKI

19a. Informant's Name/Relationship (Type, Print)

MR. EDWARD KMIECIK

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6736 BESSEMER AVENUE BALTO., MD. 21222

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

ST. STANISLAUS CEMETERY

Date

2-26-96

20c. Location - City or Town, State

BALTO. MD. 21224

21. Signature of Funeral Service Licensee

Charles R. Kaczorowski

22. Name and Address of Facility

KACZOROWSKI FUNERAL HOME  
1201 DUNDALK AVENUE BALTO. MD. 2122223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Cerebrovascular Accident

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

5 hours

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Myocardial Infarction

Due to (or as a consequence of):

5 hours

c. Vascular Disease

Due to (or as a consequence of):

years

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural  
2 ☐ Accident  
3 ☐ Suicide  
4 ☐ Homicide5 ☐ Pending  
investigation  
6 ☐ Could not be  
determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how Injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dodd J. Cox, MD

29c. License number

JHBMC-96015

29d. Date signed (Month, Day, Year)

February 22, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Johns Hopkins Bayview Medical Center, Eastern Avenue, Baltimore, MD.

31. Date filed (Month, Day, Year)

FEB 23 1996

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04658

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

EVELYN M. MAGUIRE

2. Date of Death

FEB 22, 1996

3. Time of Death

5 AM

4a. Facility Name (If not institution, give street and number)

FRANKLIN SQUARE HOSPITAL

4b. City, Town, or Location of Death

N/A

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

213-30-4527

8. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

JUNE 19, 1922

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

N/A

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7404 GUNPOWDER ROAD

10f. Zip Code

21220

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8TH

College (14 or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOME MAKER

16b. Kind of Business/Industry

HOME

17. Father's Name (First, Middle, Last)

OLAF STROMBLAD

18. Mother's Name (First, Middle, Maiden Surname)

SOPHIA RYNIOWICZ

19a. Informant's Name/Relationship (Type, Print)

MICHAEL J. MAGUIRE JR.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12329 HARFORD ROAD KINGSVILLE MARYLAND 21087

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

OAK LAWN CEM

Date

1/24

20c. Location - City or Town, State

baltimore

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

HARTLEY MILLER FUNERAL HOME

7527 HARFORD ROAD BALTIMORE MARYLAND 21234

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *end stage pulmonary*  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*chronic gi bleeding*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☒ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D20673

29d. Date signed (Month, Day, Year)

2/23/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

George Lowe on Belair RD 5810 21206

31. Date filed (Month, Day, Year)

FEB 23 1996

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



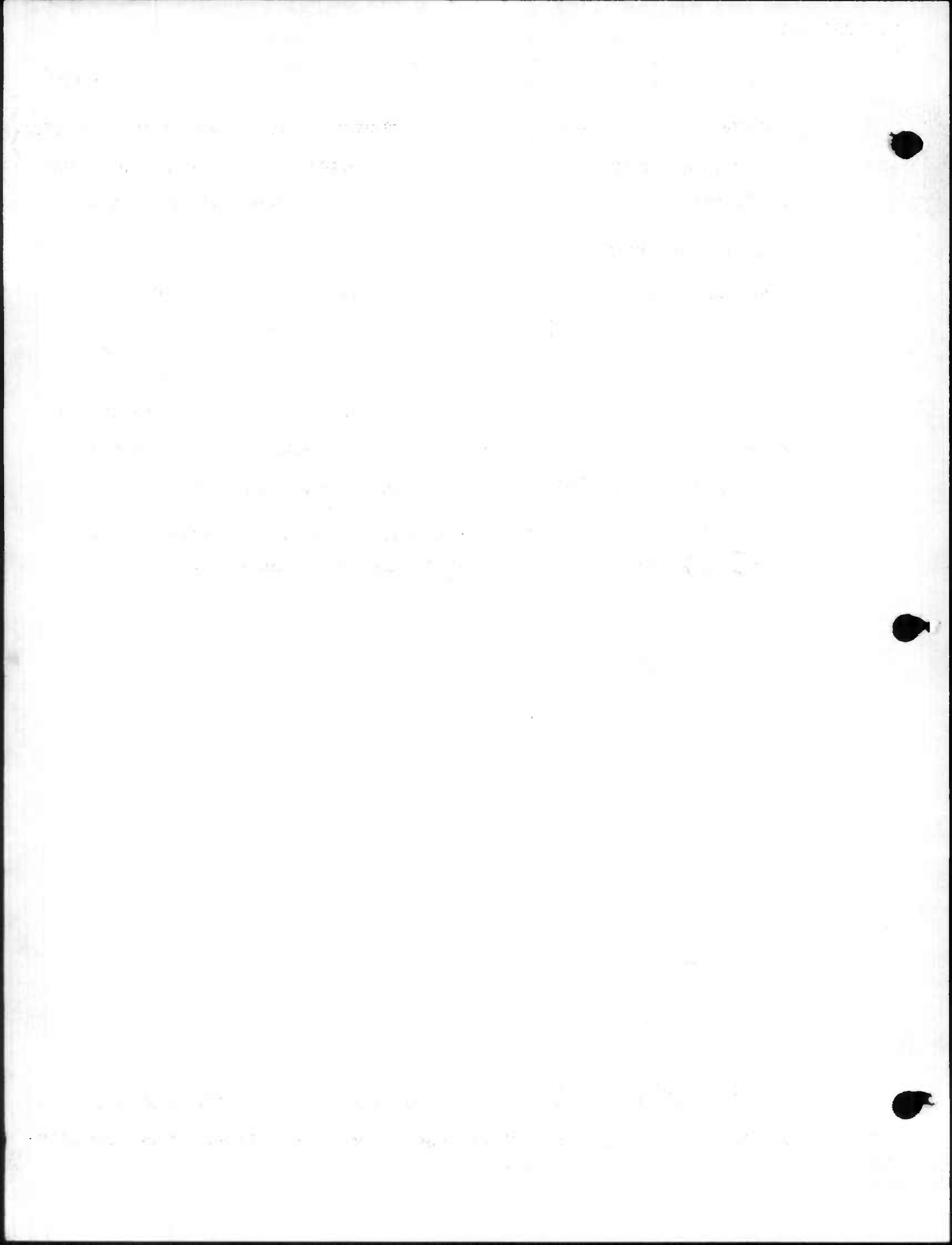
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

ITEMS: 23 PART I, 27, 28a-f, State of Maryland / Department of Health and Mental Hygiene  
PER MEO FILM G-733 3/4/96 t.t

## Certificate of Death

Reg. No. 96 04659

|   |  |  |  |  |   |  |   |  |
|---|--|--|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>COLBERT ANTHONY MOUZEN</b>  |  |  |  | 2. Date of Death<br>Month Day Year<br><b>FEBRUARY 20, 1996</b>  |  | 3. Time of Death<br><b>0205AM</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>761 SEAWALL ROAD</b>  |  |  |  | 4b. City, Town, or Location of Death<br><b>ESSEX</b>  |  | 4c. County of Death<br><b>BALTIMORE COUNTY</b>  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>219 78 5789</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>24</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>Feb. 15, 1972</b>   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Essex</b>   |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  | 10e. Street and Number<br><b>761 Seawall Rd.</b>  |  | 10f. Zip Code<br><b>21221</b>   |  |
|   | 10g. Citizen of What Country?<br><b>United States</b>  |  |  |  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever In U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)                       |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Childcare Worker</b>   |  |  |  | 16b. Kind of Business/Industry<br><b>Group Home non-profit</b>  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br><b>Colbert Mouzen</b>   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Henrietta Townsend</b>  |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>David M. Hutchinson/ Foster Brother</b>   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>620 C Harborside Dr., Joppa, MD 21085</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Green Mount Crematory</b>  |  | 20c. Location - City or Town, State<br><b>2/22/96 Baltimore, MD</b>   |  |
|   | 21. Signature of Funeral Service Licensee<br>  |  |  |  | 22. Name and Address of Facility<br><b>CAFA Stephen D. Lohrmann P.A.<br/>8717 Green Pastures Dr., Baltimore, MD 21286</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><b>COCAINE INTOXICATION</b><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):                     |  |  |  |   |  |   |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |  |  |   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |
|   | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br><input type="checkbox"/> Natural <input checked="" type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  |  |  | 28a. Date of Injury (Month, Day Year)<br><b>FOUND 2/19/96</b>   |  | 28b. Time of Injury<br><b>11:06 PM</b>  |  |
|   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  | 28d. Describe how Injury occurred<br><b>UNKNOWN</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>FOUND BY ROOMMATE IN 2ND FLOOR BATHROOM</b>   |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>761 SEAWALL ROAD BALTIMORE, MD.</b>  |  |   |  |
|   | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 29b. Signature and title of certifier<br>  |  |  |  | 29c. License number<br><b>O.C.M.E.</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>FEBRUARY 20, 1996</b>   |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>111 Penn Street, Baltimore, Maryland 21201</b>  |  |  |  |   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 31. Date filed (Month, Day, Year)<br><b>FEB 23 1996</b>  |  |  |  | 32. Registrar's Signature<br>   |  |   |  |
|   | State Registrar  |  |  |  |   |  |   |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item 23c, Part 1, 27, 29a, Film 732, 2/23/96, 1t

Certificate of Death

Reg. No. 96 04660

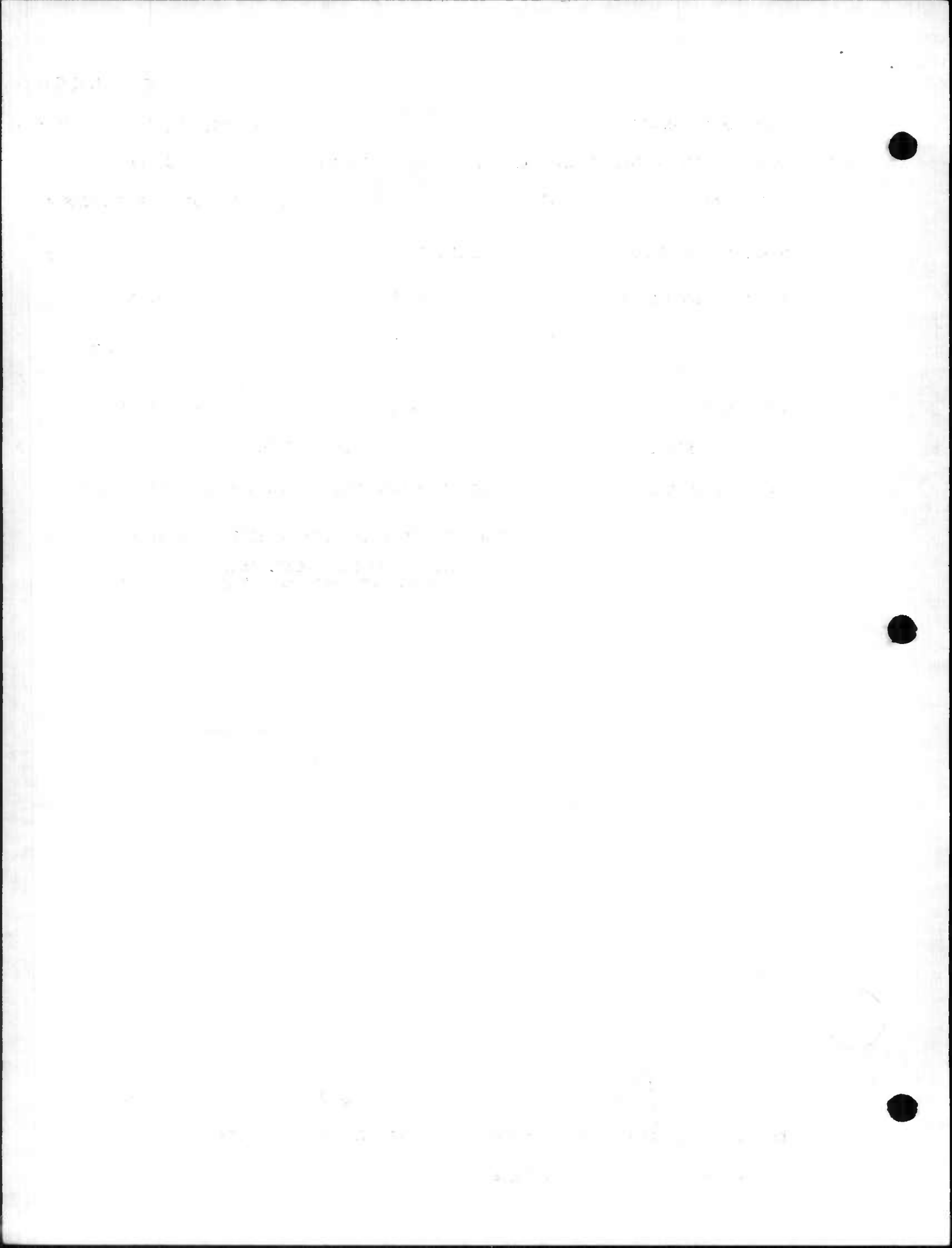
|   |  |  |   |  |  |  |  |  |  |  |
|---|--|--|---|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>HELEN J. NORRIS  |  |   |  |  |  | 2. Date of Death<br>Month Day Year<br>FEBRUARY 18, 1996          |  | 3. Time of Death<br>12:10 P.M.   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>DULANEY-TOWSON HEALTH CARE CENTER  |  |   |  |  |  | 4b. City, Town, or Location of Death<br>TOWSON                   |  | 4c. County of Death<br>BALTIMORE   |  |
| Funeral<br>Director   | 5. Social Security Number<br>212-05-2266   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>88 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>AUG. 17, 1907             |  | 9. Birthplace (State or Foreign Country)<br>PENNSYLVANIA   |  |
|   | Usual Residence of Decedent  |  |   |  |  |  |  |  |  |  |
| To Be Completed by Funeral Director   | 10a. State<br>MARYLAND   |  | 10b. County<br>BALTIMORE  |  | 10c. City, Town or Location<br>TIMONIUM  |  |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
|   | 10e. Street and Number<br>101 NORTHWOOD DRIVE  |  |   |  | 10f. Zip Code<br>21093   |  | 10g. Citizen of What Country?<br>U.S. A.                         |  |  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12TH GRADE<br>College (1-4 or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>OWNER   |  |  | 16b. Kind of Business/Industry<br>RESTAURANT                     |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>LOUIS P. HAIGIS   |  |   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>MARY WUNDER |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>NANCY L. NORRIS  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>101 NORTHWOOD DRIVE - LUTHERVILLE, MD 21093   |  |  |  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>MEADOWRIDGE MEMORIAL PARK  |  | 20c. Location - City or Town, State<br>2/21/96 ELKRIDGE          |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br><i>Jackie D. Shanno</i>   |  |   |  | 22. Name and Address of Facility<br>HUBBARD FUNERAL HOME, INC.<br>4107 WILKENS AVENUE-BALTIMORE, MD 21229  |  |  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <i>Respiratory failure</i><br>Due to (or as a consequence of):<br>b. <i>COPD</i><br>Due to (or as a consequence of):<br>c. <i>Cervical Cancer - Secondary</i><br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |  |  |  |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  |  |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |  |   |  |  |  |  |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |   |  |  |  |  |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |   |  |  |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |   |  |  |  |  |  |  |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |  |   |  |  |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  |  |   |  |  |  |  |  |  |  |
| 28a. Date of Injury (Month, Day, Year)  |  |  |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how Injury occurred                                |  |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |  |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |   |  |  |  |  |  |  |  |
| 29b. Signature and title of certifier<br><i>[Signature]</i>   |  |  |   | 29c. License number<br>D 44796   |  |  | 29d. Date signed (Month, Day, Year)<br>2-22-96                   |  |  |  |
| 30. Name and address of person who completed Cause of death (Item 23a) (Type, Print)<br>DR. MOHAMMED AHMED - 9512 HARFORD ROAD - BALTIMORE, MD 21234  |  |  |   |  |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>FEB 23 1996  |  |  |   |  |  |  |  |  |  |  |
| 32. Registrar's Signature<br><i>[Signature]</i>   |  |  |   |  |  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item 1, Film 732, 2/23/96, 1t

## Certificate of Death

Reg. No.

96 04661

|  |  |  |   |   |   |   |  |  |
|--|--|--|---|---|---|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>JOHN<br/>Joseph Quincy Nash, Sr.</b>  |  |   |   | 2. Date of Death<br>Month Day Year<br><b>Feb. 22, 1996</b>  |   | 3. Time of Death<br><b>10:10am</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>3900 Stansbury Mill Road</b>  |  |   |   | 4b. City, Town, or Location of Death<br><b>Monkton</b>  |   | 4c. County of Death<br><b>Baltimore</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>215-18-3723</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>77</b> Yrs.  |   | 8. Date of Birth (Month, Day, Year)<br><b>July 5, 1918</b>   |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>South Carolina</b>  |  | 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>Baltimore</b>   |   | 10c. City, Town or Location<br><b>Monkton</b>  |  |
| To Be Completed by<br>Funeral Director   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>3900 Stansbury Mill Road</b>   |   | 10f. Zip Code<br><b>21111</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>n/a</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Caretaker</b>   |   | 16b. Kind of Business/Industry<br><b>Private Property</b>   |   |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>John Quincy Nash</b>   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lula Frazier</b>  |   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mrs. Catherine F. Nash</b>  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3900 Stansbury Mill Road, Monkton, Maryland 21111</b>   |   |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Dulaney Valley Mem. Grdns Feb</b>  |   | 20c. Location - City or Town, State<br><b>Timonium, Maryland</b>  |   |  |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Bryan W. Clary</b>   |  | 22. Name and Address of Facility<br><b>Lemmon Funeral Home of Dulaney Valley, Inc.<br/>10 W. Padonia Rd. Timonium, MD 21093</b>   |   |   |   |  |  |
|  | 23a. Pertinent disease, or complications that caused the shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined |   | 28a. Date of Injury (Month, Day Year)<br><b>M</b>  |  |
|  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 28d. Describe how injury occurred   |   | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><b>Ceballos, MD</b> |   | 29c. License number<br><b>D 25886</b>           |   | 29d. Date signed (Month, Day, Year)<br><b>2-22-96</b> |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Lilia Ceballos, M.D., O'Day Bldg., Suite 501, Towson, MD 21204</b>  |  | 31. Date filed (Month, Day, Year)<br><b>FEB 23 1996</b>      |   | 32. Registrar's Signature<br><b>[Signature]</b> |   |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04662

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

PAUL PATLABA

2. Date of Death

FEB 19 1996 S:30pm

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

St. Agnes Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

220-64-3972

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

41

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

06/18/1954

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

3550 Benzinger Road

10f. Zip Code

21229

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
016a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Manager

16b. Kind of Business/Industry

Lithuanian Hall

17. Father's Name (First, Middle, Last)

Juozas Patlaba

18. Mother's Name (First, Middle, Maiden Surname)

Vale Jerumbaускаite

19a. Informant's Name/Relationship (Type, Print)

Maria Patlaba Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3550 Benzinger Rd. Baltimore, Md 21229

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Louden Park Cemetery

Date

2/23

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Kathleen Weber CFSP

22. Name and Address of Facility

David J. Weber Funeral Home  
5311 Edmondson Ave. Baltimore, Md 2122923a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. ANOXIC ENCEPHALOPATHY

Due to (or as a consequence of):

b. FALL

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

c.

Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

90 HRS

91 HRS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
Investigation  
2 ☒ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)

FEB 15, 1996

28b. Time of  
Injury

10:00 PM

28c. Injury at  
Work?1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

FALL

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

HOME

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

3550 BENZINGER RD BALTIMORE

29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Myung Nam, M.D.

29c. License number

D35106

29d. Date signed (Month, Day, Year)

FEB 19, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MYUNG NAM, M.D. ST. AGNES HOSPITAL, BALTIMORE, MD

31. Date filed (Month, Day, Year)

FEB 23 1996

32. Registrar's Signature

John H. [Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: This requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

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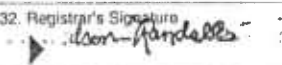
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State of Maryland / Department of Health and Mental Hygiene

Item: 1, Film 732, 2/23/96, 1t

## Certificate of Death

Reg. No. 96 04663

|   |  |  |   |  |  |  |   |  |  |  |  |  |
|---|--|--|---|--|--|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>GEORGE RICHARD PURDY JR  |  |   |  | 2. Date of Death<br>Month Day Year<br>February 21, 1996  |  |   |  | 3. Time of Death<br>1:20 A.M.  |  |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Stella Maris Hospice   |  |   |  | 4b. City, Town, or Location of Death<br>Towson   |  |   |  | 4c. County of Death<br>Baltimore   |  |  |  |
| Funeral<br>Director                           | 5. Social Security Number<br>218-28-2505   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>63 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>April 13, 1932 |  | 9. Birthplace (State or Foreign Country)<br>Maryland   |  |  |  |
|   | 10a. State<br>Maryland   |  |   |  | 10b. County<br>Baltimore   |  |   |  | 10c. City, Town or Location<br>Baltimore   |  |  |  |
| To Be Completed by Funeral Director           | 10e. Street and Number<br>3627 Parkhurst Way   |  |   |  | 10f. Zip Code<br>21236   |  |   |  | 10g. Citizen of What Country?<br>U.S.A.  |  |  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12th grade<br>College (1-4 or 5+) College (1-4 or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Machinist   |  |   |  | 16b. Kind of Business/Industry<br>Manufacturing Co.  |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>George R. Purdy, Sr.  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Edna Smith  |  |   |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br>Patricia S. Purdy (spouse)   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3627 Parkhurst Way, Baltimore, MD 21236   |  |   |  |  |  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Parkwood Cemetery  |  |   |  | 20c. Location - City or Town, State<br>Baltimore, Maryland   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br>Schimunek Funeral Homes, Inc.<br>9705 Belair Rd., Baltimore, MD 21236  |  |   |  |  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. LUNG CANCER / NON-SMALL CELL<br>Due to (or as a consequence of):  |  |   |  |  |  |   |  | Approximate Interval Between Onset and Death<br>1 yr.  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  |   |  | 23c. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |  |
|   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) HOSPICE |  |   |  |  |  |  |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  |   |  | 28a. Date of Injury (Month, Day Year)<br>28b. Time of Injury<br>M<br>28c. Injury at Work?<br>1 <input type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |  | 28d. Describe how injury occurred  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  | 29b. Signature and title of certifier<br>   |  |   |  | 29c. License number<br>D25643  |  |  |  |
|   | 29d. Date signed (Month, Day, Year)<br>FEBRUARY 21, 1996   |  |   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>DR. KENDALL FAULKNER 2300 DULANEY VALLEY RD. TOWSON, MD 21204  |  |   |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 31. Date filed (Month, Day, Year)<br>FEB 23 1996   |  |   |  | 32. Registrar's Signature<br>   |  |   |  |  |  |  |  |
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Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04664

|   |  |  |   |   |  |  |  |   |  |
|---|--|--|---|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>John W. Powers  |  |  |   | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>Feb 19 <sup>th</sup> 1996   |  |  |  | 3. TIME OF DEATH<br>1:40 P.M.   |  |
| 4. SOCIAL SECURITY NUMBER<br>212-50-7469  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br>48 YRS. | 7. DATE OF BIRTH (Month, Day, Year)<br>June 29, 1947  |  | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland                                 |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Union Memorial Hospital   |  |  |   | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore City   |  |  |  | 9c. COUNTY OF DEATH<br>N/A  |  |
| 10a. STATE<br>Maryland  |  |  |   | 10b. COUNTY<br>Harford  |  | 10c. CITY, TOWN OR LOCATION<br>Abingdon  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>2833 Dainaway Court   |  |  |   | 10f. ZIP CODE<br>21009  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |   | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                     |  |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>10th grade  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Tractor Tractor Driver   |   | 16b. KIND OF BUSINESS/INDUSTRY<br>Trucking Industry   |  |  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Grant Major Powers   |  |  |   | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Blanche Hebbler  |  |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Nancy L. Powers (Wife)  |  |  |   | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2833 Dainaway Court, Abingdon, Md. 21009   |  |  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Bel Air Memorial Gardens 2/24/96  |   | 20c. LOCATION — City or Town, State<br>Bel Air, Maryland  |  |  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Robert J. Madach, Jr.  |  |  |   | 22. NAME AND ADDRESS OF FACILITY<br>Schimunek Funeral Home of Bel Air, Inc.<br>610 W. MacPhail Road, Bel Air, Md. 21014   |  |  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>respiratory failure</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <u>metastatic melanoma</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> |  |  |   |   |  |  |  | Approximate Interval Between Onset and Death<br>m.w.k.<br>5 months                                  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |   |   |  |  |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |  |  |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |   | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |   | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |   |   |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>[Signature] M.D.   |  |  |   | 29c. LICENSE NUMBER<br>044947   |  | 29d. DATE SIGNED (Month, Day, Year)<br>2/19/96                                       |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Union Memorial Hospital Baltimore, md 21218  |  |  |   |   |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>FEB 23 1996  |  |  |   | 32. REGISTRAR'S SIGNATURE<br>John Madach, Jr.   |  |  |  |   |  |



TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR  |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 96 04665  |  |  |  |
|---|--|--|--|---|--|--|--|---|--|--|--|
| CERTIFICATE OF DEATH  |  |  |  | REG. NO.  |  |  |  |   |  |  |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Arthur Pickard</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>February 15, 1996</b>  |  |  |  | 3. TIME OF DEATH<br><b>1047A M</b>  |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>236-28-6567</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>72</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>March 8, 1923</b>                      |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Pennsylvania</b>                                       |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>VA Medical Center</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>   |  |  |  | 9c. COUNTY OF DEATH<br><b>n/a</b>   |  |  |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Harford</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Bel Air</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO       |  |  |  |
| 10e. STREET AND NUMBER<br><b>201 Broadview Avenue</b>   |  |  |  | 10f. ZIP CODE<br><b>21014</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>5/7/43 to 1/3/46</b>  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                               |  |  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th grade</b><br>College (1-4 or 5+) <b>4 years</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Music Teacher</b>  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Education</b>  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Paul Stillwagon Pickard</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Donna Rhodes</b>  |  |  |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print) (wife)<br><b>Dorothy Pickard</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>201 Broadview Avenue-Bel Air, Maryland 21014</b>  |  |  |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>DATE</b>   |  | 20c. LOCATION — City or Town, State   |  |  |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Ronald S. Wade, Dir.</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>State Anatomy Board-655 W. Baltimore Street<br/>Rm.B026-Baltimore, Maryland 21201-1559</b>   |  |  |  |   |  |  |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Adult Respiratory Distress Syndrome</b><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. <b>Sepsis</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <b>Renal Cell Carcinoma</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |  |  | Approximate Interval Between Onset and Death<br><b>5 days</b><br><b>2 weeks</b>                       |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>   |  |  |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |   |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Paul B. Syman MD</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>P 09810</b>   |  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>2/15/96</b>   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Paul B. Syman 22. South Greene St. Baltimore Md 21201</b>   |  |  |  |   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 23 1996</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Shirley Ann Rucker</b>  |  |  |  |   |  |  |  |





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 96 04666

|   |   |  |   |  |  |  |  |  |
|---|---|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>VINSTON PIPKIN (muhammad Hafeez)  |  |   |  | 2. Date of Death<br>Month 2 Day 17 Year 96   |  | 3. Time of Death<br>1410   |  |
|   | 4a. Facility Name (If not Institution, give street and number)<br>8900 Dogwood Rd   |  |   |  | 4b. City, Town, or Location of Death<br>Randallstown   |  | 4c. County of Death<br>Balto   |  |
| Funeral<br>Director   | 5. Social Security Number<br>220-03-1846  |  | 6. Sex<br>M <input checked="" type="checkbox"/> F <input type="checkbox"/>  |  | 7. Age (In yrs. last birthday)<br>84 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>May 5, 1911                                   |  |
|   | 9. Birthplace (State or Foreign Country)<br>N.C.  |  | 10a. State<br>md  |  | 10b. County<br>Balto   |  | 10c. City, Town or Location<br>Randallstown  |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br>8900 Dogwood Rd   |  | 10f. Zip Code<br>21244   |  | 10g. Citizen of What Country?<br>U.S.A   |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: Black                     |  |
| To Be Completed by Physician/Medical Examiner   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8th College (1-4 or 5+) n/a  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Coil Maker   |  | 16b. Kind of Business/Industry<br>steel  |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>Lawrence Pipkin  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Ina Pipkins  |  | 19a. Informant's Name/Relationship (Type, Print)<br>Ameena Parker  |  |  |  |
| Physician<br>/Medical<br>Examiner   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3244 yosemite Ave Balto, md 21215  |  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>King Memorial Pk   |  | 20c. Location - City or Town, State<br>Randallstown, md                              |  |
|   | 21. Signature of Funeral Service Licensee<br>Gabrielle Cook   |  | 22. Name and Address of Facility<br>Mann F.H. West<br>4300 Warbush Ave  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Chronic arteriosclerotic cardiovascular disease<br>a. Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of): |  |  |  |
| Division of Vital Records, P.O. Box 68760,<br>Baltimore, Maryland 21215-0020  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |  |  |  |
|   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner  | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
|   | 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br>J. Crossan O'Donovan, M.D.   |  | 29c. License number<br>D07632  |  | 29d. Date signed (Month, Day, Year)<br>2-19-96                                       |  |
| State Registrar   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>J. Crossan O'Donovan, M.D., 2112 DUNDALK AVE, BALTO MD 21222  |  | 31. Date filed (Month, Day, Year)<br>FFR 23 1996  |  | 32. Registrar's Signature<br>11: [Signature]   |  |  |  |



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR  |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 96 04667  |  |
|---|--|--|--|---|--|---|--|---|--|
| CERTIFICATE OF DEATH  |  |  |  | REG. NO.  |  |   |  |   |  |
| 1. DECEASED'S NAME (First, Middle, Last)<br><b>DOLORES PAUL</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>FEBRUARY</b> DAY <b>8</b> YEAR <b>96</b>   |  |   |  | 3. TIME OF DEATH<br><b>11:30 P M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>220-24-1213</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>69</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>July 9, 1926</b>                               |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Copper Ridge 710 Obrecht Rd</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Sykesville, MD 21784</b>  |  |   |  | 9c. COUNTY OF DEATH<br><b>Carroll Co.</b>   |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Carroll</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Sykesville</b>  |  |   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO       |  |
| 10e. STREET AND NUMBER<br><b>710 Obrecht Road</b>   |  |  |  | 10f. ZIP CODE<br><b>21784</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                     |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>  |  | 15b. College (1-4 or 5+)<br><b>0</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Salesperson</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Retail</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Louis Paul</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mae Wagner</b>  |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Marlene Paul-Becker</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7910 Diehlwood Road-Baltimore, Maryland 21222</b>   |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)  |  | DATE  |  | 20c. LOCATION — City or Town, State   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Ronald S. Wade, Dir.</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>State Anatomy Board-655 W. Baltimore Street<br/>Rm. B026-Baltimore, Maryland 21201-1559</b>  |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Atherosclerotic Coronary Vascular Disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely ill condition, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |   |  | Approximate Interval Between Onset and Death<br><b>20 yrs</b>   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Diabetes Mellitus</b>  |  |  |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |   |  |   |  |   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  |   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURED  |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Robert L. Moss, MD</b>   |  |   |  |   |  | 29c. LICENSE NUMBER<br><b>032082</b>  |  |
| 29d. DATE SIGNED (Month, Day, Year)<br><b>2/9/96</b>  |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Robert L. Moss 114 Business Center Drive Reisterstown, Md</b>  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 23 1996</b>   |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Karball</b>   |  |   |  |   |  | 2176  |  |

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04668

|   |  |   |   |  |  |  |  |  |
|---|--|---|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>LOUIS EUGENE PARTY</b>  |   |   |  | 2. Date of Death<br>Month <b>FEBRUARY</b> Day <b>19th</b> Year <b>1996</b>   |  | 3. Time of Death<br><b>8:58 AM</b>   |  |
|   | 4e. Facility Name (If not institution, give street and number)<br><b>HARBOR HOSPITAL CENTER</b>  |   |   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |  | 4c. County of Death<br><b>BALTIMORE CITY</b>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>218-28-9128</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>64</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>June 12, 1931</b>  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Georgia</b>   |   | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Baltimore</b>  |  | 10c. City, Town or Location<br><b>Edgemere</b>   |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 10e. Street and Number<br><b>46 Shore Road</b>  |  | 10f. Zip Code<br><b>21219</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>Korean</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12 Years</b><br>College (14 or 5+) <b>College (14 or 5+)</b>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Crane Operator</b>                              |  | 16b. Kind of Business/Industry<br><b>Construction</b>  |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Lucien Emile Party</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Jessie Lear Paulk</b>  |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mrs. Betty L. Party</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>46 Shore Road Edgemere, Maryland 21219</b>   |  |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Holly Hill Mem. Gdns. 2/22/96</b>  |  | 20c. Location - City or Town, State<br><b>Middle River, MD</b>   |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br>  |   |   |  | 22. Name and Address of Facility<br><b>Duda-Ruck Funeral Home of Dundalk, Inc.<br/>7922 Wise Ave. Dundalk, Maryland 21222</b>  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>CARDIOGENIC SHOCK</b><br>Due to (or as a consequence of):<br><br>b. <b>COMPLETE HEART BLOCK</b><br>Due to (or as a consequence of):<br><br>c. <b>GLOBAL MYOCARDIAL INFARCTION</b><br>Due to (or as a consequence of):<br><br>d. <b>ATHROSCLEROTIC CORONARY ARTERY DISEASE</b><br>Due to (or as a consequence of):<br><br>Approximate Interval Between Onset and Death<br><b>2 hours</b><br><b>1 day</b><br><b>1 day</b><br><b>15 years</b> |   |   |  |  |  |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b>   |   |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|   |  |   |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |
|   |  |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>            |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |
|   |  | 28d. Describe how injury occurred   |   |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |
|   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |   |  |  |  |  |  |
| 29b. Signature and title of certifier<br>   |  |   |   | 29c. License number<br><b>AS2441614-16</b> |  | 29d. Date signed (Month, Day, Year)<br><b>FEBRUARY 19th 1996</b>   |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>K. AMBALAVANAR, HARBOR HOSPITAL CENTER · 3001 SOUTH HANOVER STREET</b>   |  |   |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 23 1996</b>   |  | 32. Registrar's Signature<br>   |   |  |  |  |  |  |

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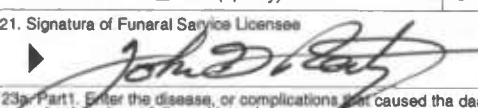
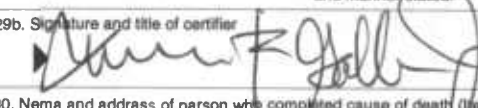

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 96 04669

|  |   |   |   |   |   |   |  |  |
|--|---|---|---|---|---|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>JOHN PRINCIPIO  |   |   |   | 2. Date of Death<br>Month Day Year<br>FEB. 20, 1996   |   | 3. Time of Death<br>3:28 PM.   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>6209 CHINQUAPIN PKWY.   |   |   |   | 4b. City, Town, or Location of Death<br>BALTIMORE   |   | 4c. County of Death<br>N/A   |  |
| Funeral<br>Director  | 5. Social Security Number<br>216-52-2714  |   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br>48 Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br>FEB. 9, 1948  |  |
|  | 9. Birthplace (State or Foreign Country)<br>Maryland  |   | 10a. State<br>Maryland  |   | 10b. County<br>N/A  |   | 10c. City, Town or Location<br>Baltimore City  |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   | 10e. Street and Number<br>6209 Chinquapin Parkway   |   | 10f. Zip Code<br>21239  |   | 10g. Citizen of What Country?<br>U.S.A.  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) Collega (1-4or 5+)<br>5+   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Soils Engineer                           |   | 16b. Kind of Business/Industry<br>Engineering Firm  |   |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>John Francis Principio, Sr.  |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Josephine Mary Della Noce  |   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>Patricia M. Principio/ wife   |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>6209 Chinquapin Parkway, Baltimore, Maryland 21239   |   |  |  |
|  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Green Mount Crematory   |   | 20c. Location - City or Town, State<br>FEB.22 Baltimore, Maryland   |   |  |  |
|  | 21. Signature of Funeral Service Licensee<br>   |   | 22. Name and Address of Facility<br>Mitchell-Wiedefeld Home, Inc.<br>6500 York Road, Baltimore, Maryland 21212  |   |   |   |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death) a. <u>HANGING</u><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last {<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of): |   |   |   |   |   |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |   |   |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |
|  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |   |   |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |   |   |  |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)<br>2-20-96  |   | 28b. Time of Injury<br>1500 P M   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |  |
| 28d. Describe how injury occurred<br>SUBJECT HANGED SELF   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>HOME  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>6209 CHINQUAPIN PKWY, BALTIMORE |   |   |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br>  |   | 29c. License number<br>O.C.M.E.   |   | 29d. Date signed (Month, Day, Year)<br>FEB. 21, 1996  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>MARIO F. GOLIS JK MD 111 Penn Street, Baltimore, Maryland 21201  |   |   |   |   |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br>FEB 23 1996   |   | 32. Registrar's Signature<br>  |   |   |   |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

12

Page 1

1. The first part of the report is a general introduction to the subject.

2. The second part is a detailed description of the methods used.

3. The third part is a discussion of the results obtained.

4. The fourth part is a conclusion and summary of the work.

5. The fifth part is a list of references.

6. The sixth part is a list of figures.

7. The seventh part is a list of tables.

8. The eighth part is a list of appendices.

9. The ninth part is a list of footnotes.

10. The tenth part is a list of errata.

11. The eleventh part is a list of acknowledgments.

12. The twelfth part is a list of references.

13. The thirteenth part is a list of footnotes.

14. The fourteenth part is a list of errata.



ITEM#10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
item# 9,17,18 3/01/96 ag fil# 733 per FH Certificate of Death

Reg. No.

96 04670

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Louis

Rode

2. Date of Death

Feb. 16, 1996

Year

3. Time of Death

6:30pm

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

715 Whitehall Beach Road

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

5. Social Security Number

331-10-0674

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

87

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jun. 4, 1908

9. Birthplace (State or Foreign)

Chicago, Ill.

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

715 Whitehall Beach Road, Annapolis

10d. Inside City Limits

Yes ☐ No ☒

10e. Street and Number

715 Whitehall Beach Road

10f. Zip Code

21401

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

To Be Completed by Funeral Director

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Manager

16b. Kind of Business/Industry

Steel Industry

17. Father's Name (First, Middle, Last)

Unknown

ANDREW SUHADOLINK

Rode

18. Mother's Name (First, Middle, Maiden Surname)

Unknown

MARY SVEET

19a. Informant's Name/Relationship (Type, Print)

L. A. Lutz

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

715 Whitehall Beach Road, Annapolis, MD 21401

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Metro Crematory

Date

2/20/96

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

B. B. B. B.

22. Name and Address of Facility

Hardesty Funeral Home, P.A.  
12 Ridgely Ave. Annapolis, MD 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac Arrest (presumed vent. fibrillation)

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Immed

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Coronary Artery Disease

Due to (or as a consequence of):

5+ yrs.

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Congestive Heart Failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

A. B. B.

29c. License number

000561

29d. Date signed (Month, Day, Year)

2/19/96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Robert Biern, M.D. 900 Bestgate Rd, #300, Annapolis, Md. 21401

31. Date filed (Month, Day, Year)

FEB 23 1996

32. Registrar's Signature

John B. B. B.

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



1 -  
FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04671

|  |  |  |  |   |  |  |   |
|--|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><del>BB WILLET</del> <del>BRUCE</del> CLIFTON RICKS  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>FEBRUARY 20, 1996   |  | 3. TIME OF DEATH<br>10:30AM M  |   |
| 4. SOCIAL SECURITY NUMBER<br>none  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>YRS. MONTHS DAYS  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>JAN. 19, 1996  |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br>THE JOHNS HOPKINS HOSPITAL   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE CITY   |  | 9c. COUNTY OF DEATH<br>n/a   |   |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |  |   |
| 10a. STATE<br>MD   |  | 10b. COUNTY<br>n/a   |  | 10c. CITY, TOWN OR LOCATION<br>BALTIMORE  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |   |
| 10e. STREET AND NUMBER<br>5516 WHITWOOD ROAD   |  |  |  | 10f. ZIP CODE<br>21206  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>UNITED STATES   |   |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: BLACK   |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) none<br>College (1-4 or 5+) -  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>BABY  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>n/a   |  |  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>CLIFTON RICKS   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><del>Willet</del> BRUCE RICKS  |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>WILETTE RICKS  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>5516 WHITWOOD ROAD, BALTIMORE, MD 21206  |  |  |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>VOSHELL MEMORIAL GARDENS 2-23 DUNDALK, MD   |  | 20c. LOCATION — City or Town, State   |  |  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>WM. C. MARCH FH.-1101 E. NORTH AVENUE   |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |  |   |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  | a. Pulmonary Hypoplasia<br>DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |  | Approximate interval Between Onset and Death<br>1 month |
|  |  | b. Pulmonary Hypertension<br>DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |  | 1 month   |
|  |  | c. Congenital Diaphragmatic Hernia<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |  | 1 month   |
|  |  | d.   |  |   |  |  |   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Left middle cerebral artery infarction   |  |  |  |   |  |  |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |   |
|  |  | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28e. DESCRIBE HOW INJURY OCCURRED   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Madhu Nigam (Fellow)  |  |  |  | 29c. LICENSE NUMBER<br>J 6087   |  | 29d. DATE SIGNED (Month, Day, Year)<br>February 20, 1996   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Madhu Nigam, Department of Pediatrics Johns Hopkins Hospital  |  |  |  |   |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br>FEB 23 1996   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

15700 22

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 96 04672

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Martha Elizabeth Streett

2. Date of Death  
Month Day Year  
February 18, 19963. Time of Death  
12:38 PM

4a. Facility Name (If not institution, give street and number)

1017 North Iris Avenue

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

214-22-1002

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

69

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb. 22, 1926

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1017 North Iris Avenue

10f. Zip Code

21205

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)  
10th grade

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working  
life. DO NOT use retired)

Ceramist

16b. Kind of Business/Industry

Ceramic Shop  
Self-Employed

17. Father's Name (First, Middle, Last)

Walter V. Litton

18. Mother's Name (First, Middle, Maiden Surname)

Zelphia Ann Richardson

19a. Informant's Name/Relationship (Type, Print)

Donald C. Diercks (Brother-In-Law)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1017 North Iris Avenue, Baltimore, Maryland 21205

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Bel Air Mem. Gardens 2/21/96

Date

20c. Location - City or Town, State

Bel Air, Maryland

21. Signature of Funeral Service Licensee

Math O. Crut

22. Name and Address of Facility

Schimunek Funeral Home  
3331 Brehms Lane, Baltimore, Maryland 2121323a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. Metastatic adenocarcinoma

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

18 months

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cocaine only thoria  
chronic pain syndrome

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Marvin J. Feldman MD

29c. License number

007930

29d. Date signed (Month, Day, Year)

February 20, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARVIN J. FELDMAN, MD. 301 ST. PAUL PL. #407T BALTO, MD. 21202

31. Date filed (Month, Day, Year)

FEB 23 1996

32. Registrar's Signature

John H. H. H. H.

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04673

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEASED'S NAME (First, Middle, Last)<br><i>Catherine M. Steychacz</i>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><i>February 18 1996</i>  |  | 3. TIME OF DEATH<br><i>6:20 PM</i>   |  |
| 4. SOCIAL SECURITY NUMBER<br><i>216-20-7968</i>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><i>80</i> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><i>April 20, 1915</i>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>Fallston General Hospital</i>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Fallston</i>   |  | 9c. COUNTY OF DEATH<br><i>Harford</i>  |  |
| RESIDENCE OF DECEASED  |  |  |  |  |  |  |  |
| 10a. STATE<br><i>Maryland</i>  |  | 10b. COUNTY<br><i>Harford</i>  |  | 10c. CITY, TOWN OR LOCATION<br><i>Bel Air</i>  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br><i>244 Point to Point Square</i>   |  |  |  | 10f. ZIP CODE<br><i>21015</i>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>White</i>  |  |
| 15. DECEASED'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>N/A</i><br>College (1-4 or 5+) <i>N/A</i>   |  | 16a. DECEASED'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>Assembly Line Worker</i>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>Crown, Cork &amp; Seal</i>  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>John Moroz</i>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Mary Marie Szwec</i>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Eleanor C. Apicella (Daughter)</i>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>244 Point to Point Square, Bel Air, Md. 21015</i>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                      |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place)<br><i>Holly Hill Memorial Gardens 2/22/96</i>   |  | 20c. LOCATION — City or Town, State<br><i>Baltimore, Maryland</i>  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>Schimunek Funeral Home of Bel Air, Inc.<br/>610 W. MacPhail Road, Bel Air, Md. 21014</i>                    |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>  |  |  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Congestive Heart Failure</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><i>Ruptured Thoracic Aneurysm</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Subarachnoid Hemorrhage</i>   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>J. Douglas Abbott</i>  |  |  |  | 29c. LICENSE NUMBER<br><i>D 23446</i>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>2/18/96</i>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>J. Douglas Abbott Suite 106 1716 Harford Rd Fallston Md 21042</i>  |  |  |  |  |  |  |  |
| 31. DATE OF DEATH<br><i>FEB 23 1996</i>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John A. [Signature]</i>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 96 04674

|   |  |  |   |  |  |  |  |  |
|---|--|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>Margarete SLOAN  |  |   |  | 2. Date of Death<br>Month Day Year<br>February 20, 1996  |  | 3. Time of Death<br>11:00 pm   |  |
|   | 4a. Facility Name (If not Institution, give street and number)<br>FRANKLIN SQUARE Hosp.  |  |   |  | 4b. City, Town, or Location of Death<br>ESSEX  |  | 4c. County of Death<br>Baltimore County  |  |
| Funeral<br>Director                           | 5. Social Security Number<br>102-24-9396   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>92 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>MARCH 31, 1903  |  |
|   | 9. Birthplace (State or Foreign Country)<br>GERMANY  |  | 10a. State<br>MD.   |  | 10b. County<br>N/A   |  | 10c. City, Town or Location<br>BALTIMORE   |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 10e. Street and Number<br>5401 PURLINGTON WAY   |  | 10f. Zip Code<br>21212   |  | 10g. Citizen of What Country?<br>U.S.A.  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE   |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>CHIEF BOOKKEEPER   |  | 16b. Kind of Business/Industry<br>BANKING  |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>DAVID BLEYER  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>MARIE PETER   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br>HELGA STIRIOU  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>5401 PURLINGTON WAY BALTIMORE MD. 21212   |  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>LAKESIDE MEM. PARK FEB 26, 1996 HAMBURG, N.Y.   |  | 20c. Location - City or Town, State  |  | 20d. Location - City or Town, State  |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br>Thomas J. Skarda Jr.  |  |   |  | 22. Name and Address of Facility<br>SKARDA F.H. 2829 HUDSON ST. BALTO., MD. 21224  |  |  |  |
|   | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. <u>Pneumonia</u><br>Due to (or as a consequence of):<br><br>b. <u>Malnutrition</u><br>Due to (or as a consequence of):<br><br>c. <u>Spinal Stenosis of Lumbar Region</u><br>Due to (or as a consequence of):<br><br>d. _____<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
|   |  |  |   |  |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how Injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
|   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 29b. Signature and title of certifier<br>Randell Sehres MD   |  |   |  | 29c. License number<br>P07639  |  | 29d. Date signed (Month, Day, Year)<br>February 20, 1996   |  |
|   | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>Randell Sehres, M.D. 9000 Franklin Square Drive, Baltimore, Maryland 21237   |  |   |  |  |  |  |  |
| State Registrar                               | 31. Date filed (Month, Day, Year)<br>FEB 23 1996   |  |   |  | 32. Registrar's Signature<br>Julia [Signature]   |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Handwritten text at the top of the page, possibly a header or introductory paragraph.

Second block of handwritten text, continuing the narrative or list.

Third block of handwritten text, appearing as a separate section or entry.

Large block of handwritten text in the middle of the page, possibly a detailed description or a long list.

Handwritten text at the bottom of the page, possibly a conclusion or footer.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04675

|  |  |  |  |   |  |  |  |   |  |
|--|--|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>BOUABDALLAH SAYAH</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>February</b> DAY <b>14</b> YEAR <b>1996</b>  |  |  |  | 3. TIME OF DEATH<br><b>4:27 P M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>112-22-0993</b>  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>70</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS _____ DAYS _____   |  | IF UNDER 24 HRS.<br>HOURS _____ MIN. _____  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Baltimore Veteran Hospital</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>   |  |  |  | 9c. COUNTY OF DEATH<br><b>NA</b>  |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |  |  |   |  |
| 10a. STATE<br><b>MD</b>  |  | 10b. COUNTY<br><b>NA</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br><b>3500 E. Pratt Street</b>  |  |  |  | 10f. ZIP CODE<br><b>21224</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>  |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>1944-1947</b>  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: _____ |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>Unknown</b> College (1-4 or 5+) <b>Unknown</b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>unemployed</b>   |  |  |  | 16b. KING OF BUSINESS/INDUSTRY<br><b>NA</b>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Kaddour Sayah</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Ban Arbie Zohra</b>   |  |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Rabaa B. Sayah wife</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3500 E. Pratt Street Balt. Md 21224</b>   |  |  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) _____  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>King New Park 2/19/96</b>  |  | 20c. DATE<br><b>2/19/96</b>   |  | 20d. LOCATION — City or Town, State<br><b>Randallstown Md</b>                        |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>John March</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>March F.A. West 4300 Wabash Ave Balt. Md 21215</b>   |  |  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. possible pulmonary embolus vs. myocardial infarct.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br><b>b. asthma exacerbation</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br><b>c.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br><b>d.</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |  |  | Approximate Interval Between Onset and Death  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>  |  |  |  |   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) _____ |  |   |  |  |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Snafu mD</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>MR0849</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>February 14, 1996</b>                      |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Michelle Juaneza VAMC Balt. Md 21201</b>   |  |  |  |   |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FFR 23 1996</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04676

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mary C. SCHAEFER

2. Date of Death  
Month Day Year

February 21 1996

3. Time of Death

8:40 AM

4a. Facility Name (If not Institution, give street and number)

FRANKLIN SQUARE HOSPITAL

4b. City, Town, or Location of Death

ROSEDALE

4c. County of Death

Baltimore County

Funeral  
Director

5. Social Security Number

214-20-0674

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

9-23-09

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

532 S. BELNORD AVENUE

10f. Zip Code

21224

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

9 YEARS

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

GEORGE WACHTER

18. Mother's Name (First, Middle, Maiden Surname)

ADA KEYES

19a. Informant's Name/Relationship (Type, Print)

MR. FRANK SCHAEFER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

532 S. BELNORD AVENUE BALTO. MD. 21224

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☒ Other (Specify) ENTOMBMENT

20b. Place of Disposition (Name of cemetery, crematory or other place)

HOLLY HILLS MEM PK. 2-23

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

KACZOROWSKI FUNERAL HOME  
2525 FLEET ST. BALTO. MD. 21224

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Right lower lobe pneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 days

b. Septic Shock

Due to (or as a consequence of):

3 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atrial Fibrillation

Alzheimer's dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

RD1903

29d. Date signed (Month, Day, Year)

February 21 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael Toedt, M.D. 9000 Franklin Square Drive, Baltimore, Maryland 21237

31. Date filed (Month, Day, Year)

FEB 23 1996

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. DECEASED'S NAME (First, Middle, Last)   |  |   |  | 2. DATE OF DEATH   |  |  |  | 3. TIME OF DEATH  |  |
|--|--|---|--|--|--|--|--|---|--|
| CHRISTOPHER A. SNEAD   |  |   |  | 2-9-96   |  |  |  | M   |  |
| 4. SOCIAL SECURITY NUMBER  |  | 5. SEX  |  | 6. AGE (In yrs. last birthday)   |  | 7. DATE OF BIRTH   |  | 8. BIRTHPLACE (State or Foreign Country)  |  |
| 180-34-5997  |  | 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 50 YRS.  |  | 4-11-45  |  | PENNSYLVANIA  |  |
| 9a. FACILITY NAME (If not institution, give street and number)   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH  |  |  |  | 9c. COUNTY OF DEATH   |  |
| HOPKINS- BAY VIEW  |  |   |  | BALTIMORE  |  |  |  | N/A   |  |
| RESIDENCE OF DECEDENT  |  |   |  |  |  |  |  |   |  |
| 10a. STATE   |  | 10b. COUNTY   |  | 10c. CITY, TOWN OR LOCATION  |  |  |  | 10d. INSIDE CITY LIMITS?  |  |
| MARYLAND   |  | BALTIMORE   |  | DUNDALK  |  |  |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER   |  |   |  | 10f. ZIP CODE  |  | 10g. CITIZEN OF WHAT COUNTRY?  |  |   |  |
| 2971 LIBERTY PKWY.   |  |   |  | 21222  |  | USA  |  |   |  |
| 11. MARITAL STATUS   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN?   |  | 14. RACE — American Indian, Black, White, etc.                               |  |   |  |
| 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE YEAR OR DATES<br>NAVY VIETNAM   |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>Specify:                        |  | Specify:<br>WHITE  |  |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)  |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |   |  |
| Elementary/Secondary (0-12) College (1-4 or 5 +)   |  |   |  | MECHANIC   |  | MONARCH MGMT.  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)  |  |  |  |   |  |
| HERBERT W. SNEAD   |  |   |  | CORNELLA ADAMS   |  |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)              |  |  |  |   |  |
| MRS. JACKIE SNEAD  |  |   |  | 2971 LIBERTY PKWY. BALTO. MD. 21222  |  |  |  |   |  |
| 20a. METHOD OF DISPOSITION   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of facility, street, city, state, or place)  |  | DATE   |  | 20c. LOCATION — City or Town, State  |  |   |  |
| 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | HOLLY HILLS CEM.  |  | 2-13   |  | Baltimore Co.  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  |  |   |  | 22. NAME AND ADDRESS OF FACILITY   |  |  |  |   |  |
| <i>Charles R. Kaczorowski</i>  |  |   |  | KACZOROWSKI FUNERAL HOME<br>1201 DUNDALK AVE. BALTO. MD. 21222   |  |  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |  |  |  |  | Approximate Interval Between Onset and Death  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ACUTE MYOCARDIAL INFARCTION<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |  |  |  |  | MINUTES   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  |   |  |  |  |  |  |   |  |
| b. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |  |  |  |  |   |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |  |  |  |  |   |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |  |  |  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |   |  |  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)   |  |  |  |  |  |   |  |
|  |  | HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |   |  |
| 27. MANNER OF DEATH  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY  |  | 28c. INJURY AT WORK?   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
| 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 8 <input type="checkbox"/> Could not be determined |  |   |  | M  |  | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                 |  |   |  |
|  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |  |   |  |
|  |  |   |  |  |  |  |  |   |  |
| 29a. CERTIFIER (Check only one)  |  |   |  |  |  |  |  |   |  |
| 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  |  |  |  |   |  |
| 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |  |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  |  |   |  | 29c. LICENSE NUMBER  |  | 29d. DATE SIGNED (Month, Day, Year)  |  |   |  |
| <i>John J. Loh</i> D.O.  |  |   |  | H 35593  |  | FEB. 13, 1996  |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  |  |   |  |  |  |  |  |   |  |
| DR. JOHN J. LOH 1124 MACE AVE., BALTIMORE, MD. 21221   |  |   |  |  |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)  |  |   |  |  |  |  |  |   |  |
| FEB 23 1996 <i>John Davidson-Randall</i>   |  |   |  |  |  |  |  |   |  |

11/23/2000

24 35 40 45 50 55 60 65 70 75 80 85 90 95 100



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR   |  |   |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO.  |  | 96 04678   |  |
|---|--|---|--|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><u>Margaret</u> MARGARET STEIN <u>Stein</u>   |  |   |  | 2. DATE OF DEATH<br>MONTH <u>JANUARY</u> DAY <u>02</u> YEAR <u>1996</u>   |  |   |  | 3. TIME OF DEATH<br><u>11:45 P M</u>  |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br><u>410-28-4779</u>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 6. AGE (In yrs. last birthday)<br><u>76</u> YRS. | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><u>July 13, 1919</u>  |  | 8. BIRTHPLACE (State or Foreign Country)<br><u>unknown</u>                                      |  |   |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><u>Shady Grove Hospital</u>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><u>Rockville</u>   |  |   |  | 9c. COUNTY OF DEATH<br><u>Montgomery</u>  |  |  |  |
| RESIDENCE OF DECEDENT   |  |   |  |   |  |   |  |   |  |  |  |
| 10a. STATE<br><u>Maryland</u>   |  | 10b. COUNTY<br><u>Montgomery</u>  |  | 10c. CITY, TOWN OR LOCATION<br><u>Rockville</u>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |   |  |  |  |
| 10e. STREET AND NUMBER<br><u>1235 Potomac Valley</u>  |  |   |  | 10f. ZIP CODE<br><u>20850</u>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><u>unknown</u>   |  |   |  |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><u>unknown</u>   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <u>White</u>                         |  |   |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |   |  |  |  |
| Elementary/Secondary (0-12)<br><u>unknown</u>   |  | College (1-4 or 5+)<br><u>unknown</u>   |  | <u>unknown</u>  |  | <u>unknown</u>  |  |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><u>unknown</u>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><u>unknown</u>   |  |   |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><u>unknown</u>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>unknown</u>   |  |   |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify):  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)   |  | DATE  |  | 20c. LOCATION — City or Town, State   |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><u>Ronald S. Wade, Dir.</u>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><u>State Anatomy Board-655 W. Baltimore Street<br/>Rm. B026-Baltimore, Maryland 21201-1559</u>  |  |   |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Pneumonia</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |   |  |   |  | Approximate Interval Between Onset and Death<br><u>12°</u>  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Alzheimer's dementia</u>   |  |   |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>   |  |   |  |   |  |   |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |   |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                |  | 28d. DESCRIBE NOW INJURY OCCURRED   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><u>[Signature]</u>   |  | 29c. LICENSE NUMBER<br><u>041931</u>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><u>Jan. 3, 1996</u>                                      |  |   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><u>A Shumacher, MD 9707 Med Ctr. Dr #310 Rockville, MD 20850</u>   |  |   |  |   |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><u>FEB 23 1996</u>   |  | 32. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |  |   |  |   |  |   |  |  |  |



96 04679

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>DOLORES SCHELL</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>February 19, 1996</b>   |  | 3. TIME OF DEATH<br><b>11:45 P M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>212-44-6566</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>87 YRS.</b>   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>February 15, 1909</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>RIVERVIEW NURSING CENTRE, INC.</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Essex</b>  |  |
| 9c. COUNTY OF DEATH<br><b>Baltimore</b>  |  |  |  | 10a. STATE<br><b>MD.</b>   |  | 10b. COUNTY<br><b>Baltimore</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>1 EASTERN BLVD.</b>   |  |
| 10f. ZIP CODE<br><b>21221</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6th</b> College (1-4 or 5+) <b></b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Housewife</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>n/a</b>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Frank Gross</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Margurite Mueller</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>John Wiessner</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>939 Kinwat Ave. Baltimore Md. 21221</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Metro Crematory Inc. 2/20/96 Baltimore Md.</b>   |  | 20c. LOCATION — City or Town, State  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>R. Terry Connelly</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Connelly Funeral Home of Essex<br/>300 Maco Ave. Baltimore Md. 21221</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Atherosclerosis</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Cholesterol level</b>   |  |  |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>  |  |  |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide<br>3 <input type="checkbox"/> Nomicide 8 <input type="checkbox"/> Could not be determined  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Michael Schwartz</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D19667</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>2/20/96</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>DR. MICHAEL SCHWARTZ 606 HAMMONDS LANE BALTIMORE, MD. 21225</b>  |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 23 1996</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>J. H. Sullivan</b>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



96 04680

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |   |   |  |   |  |
|--|--|--|---|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Henry George Single  |  |  |   | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>Feb. 21, 1996   |  | 3. TIME OF DEATH<br>1:50pm M  |  |
| 4. SOCIAL SECURITY NUMBER<br>216-09-6375   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br>91 YRS. | 7. DATE OF BIRTH (Month, Day, Year)<br>Sept. 27, 1904   |  | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Ivy Hall Geriatric Center  |  |  |   | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Middle River   |  | 9c. COUNTY OF DEATH<br>Baltimore  |  |
| 10a. STATE<br>Md.  |  | 10b. COUNTY<br>Baltimore   |   | 10c. CITY, TOWN OR LOCATION<br>Essex  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>1120 2C Tace Drive   |  |  |   | 10f. ZIP CODE<br>21221  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |   | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                                    |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8th<br>College (1-4 or 5+) College (1-4 or 5+)  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Material Expeditor   |   | 16b. KIND OF BUSINESS/INDUSTRY<br>Martins   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>George M. Single  |  |  |   | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Sophia Roben   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Freda Single   |  |  |   | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1120 2C Tace Drive Baltimore Md. 21221   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Holly Hill Cemetery 2/24/96   |   | 20c. LOCATION — City or Town, State<br>Baltimore Md.  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>R. Terry Connelly   |  |  |   | 22. NAME AND ADDRESS OF FACILITY<br>Connelly Funeral Home of Essex<br>300 Mace Ave. Baltimore Md. 21221   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ACUTE MYOCARDIAL INFARCTION<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. Arteriosclerotic Heart Disease<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Approximate Interval Between Onset and Death<br>10 min.<br>10 yrs. |  |  |   |   |  |   |  |
| 23. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Congestive Heart Failure<br>Alzheimer's Disease<br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |   |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |   | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |   | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                        |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |   |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>M.D.  |  |  |   | 29c. LICENSE NUMBER<br>D17728   |  | 29d. DATE SIGNED (Month, Day, Year)<br>2/22/96  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Ba Yin Oung, M.D. 8022 Belair Rd., Balto., MD 21236   |  |  |   |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>FEB 23 1996   |  |  |   | 32. REGISTRAR'S SIGNATURE<br>Julia Anderson   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


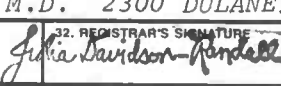
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |  |   |                                     |  |   |  | 96 04681  |   |
|---|--|--|---|--|---|-------------------------------------|--|---|--|---|---|
| 1 - FOR STATE REGISTRAR   |  |  |   |  |   |                                     |  |   |  | REG. NO.  |   |
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>JACQUELINE SCHAEFER</b>  |  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>FEB</b> DAY <b>20</b> YEAR <b>1996</b>   |                                     |  | 3. TIME OF DEATH<br><b>4:15 A M</b>   |  |   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>213-32-0528</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br><b>61</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS _____ DAYS _____  |                                     | IF UNDER 24 HRS.<br>HOURS _____ MIN. _____   |   | 7. DATE OF BIRTH (Month, Day, Year)<br><b>11-22-34</b> |   |   |
| 8a. FACILITY NAME (If not institution, give street and number)<br><b>Stella Maris</b>   |  |  |   |  | 8b. CITY, TOWN OR LOCATION OF DEATH<br><b>Towson</b>  |                                     |  | 8c. COUNTY OF DEATH<br><b>Baltimore</b>   |  |   |   |
| RESIDENCE OF DECEDENT   |  |  |   |  |   |                                     |  |   |  |   |   |
| 10a. STATE<br><b>MD</b>   |  | 10b. COUNTY<br><b>Baltimore</b>  |   | 10c. CITY, TOWN OR LOCATION<br><b>Parkville</b>  |   |                                     |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |   |   |
| 10e. STREET AND NUMBER<br><b>2135 Pitney Rd.</b>  |  |  |   |  | 10f. ZIP CODE<br><b>21234</b>   |                                     |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |                                     |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>white</b>                             |  |   |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>   |  |  |   | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Secretary</b> |   |                                     | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Advertising</b>                                 |   |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Charles Dolle</b>   |  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Katharine Linthicum</b>   |                                     |  |   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Jeannine M. Milam</b>  |  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4415 Necker Ave. Perry Hall, MD 21236</b>   |                                     |  |   |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |   | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Oak Lawn 2-23-96</b>                     |   |                                     | 20c. LOCATION — City or Town, State<br><b>Baltimore, MD</b>                          |   |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Cvach/Rosedale Funeral Home<br/>1211 Chesaco Ave.</b>  |                                     |  |   |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>MYOCARDIAL INFARCTION</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. _____<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. _____<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. _____ |  |  |   |  |   |                                     |  |   |  | Approximate Interval Between Onset and Death  |   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Diabetes mellitus coronary artery disease</b>  |  |  |   |  |   |                                     |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>   |  |  |   |  |   |                                     |  |   |  |   |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |                                     |  |   |  |   |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |                                     | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   | 28d. DESCRIBE HOW INJURY OCCURRED                      |   |   |
|   |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |                                     | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)         |   |  |   |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |   |  |   |                                     |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER   |  |  |   |  |   | 29c. LICENSE NUMBER<br><b>15506</b> |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>2 20 96</b>   |  |   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>EDDIE NAKHODA, M.D. 2300 DULANEY VALLEY RD. TOWSON, MD 21204</b>  |  |  |   |  |   |                                     |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 23 1996</b>   |  |  |   |  | 32. REGISTRAR'S SIGNATURE<br>  |                                     |  |   |  |   |   |


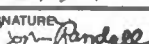
10272 73



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04682

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MAE ALBERTA TRUITT</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>FEB</b> DAY <b>11</b> YEAR <b>96</b>   |  | 3. TIME OF DEATH<br><b>9:35 P.M.</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>220-18-8968</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>86</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>08/29/1909</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Balto. MD.</b>  |  |  |  | 9a. FACILITY NAME (If not Institution, give street and number)<br><b>St. Agnes Hospital</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore City</b>   |  |
| 9c. COUNTY OF DEATH<br><b>N/A</b>  |  |  |  | 10a. STATE<br><b>MD.</b>  |  |  |  |
| 10b. COUNTY<br><b>Baltimore</b>  |  |  |  | 10c. CITY, TOWN OR LOCATION<br><b>Catonsville</b>   |  |  |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 10e. STREET AND NUMBER<br><b>11 Arkla Ct.</b>   |  |  |  |
| 10f. ZIP CODE<br><b>21228</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Home Maker</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Own Home</b>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>E. C. Jordan Bird</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Hattie Mae Mattingly</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Jordan F. Truitt /son</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>11 Arkla Court, Balto. MD. 21228</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                      |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Druid Ridge Cem. 02/14</b>                             |  | 20c. LOCATION — City or Town, State<br><b>Pikesville, MD.</b>   |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br> |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>Sterling Ashton Funeral Home, Inc.<br/>736 Edmondson Ave., Balto. MD. 21228</b>   |  |  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>BILATERAL PNEUMONIA</b><br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>e. <b>INFECTED DECUBITUS ULCERS</b><br>d. <b>CONGESTIVE HEART FAILURE</b><br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>ACUTE RENAL FAILURE</b> |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                    |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>M.D.</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>PO 9896</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>FEB 11/96</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>VIOLETA RUS - ST. AGNES HOSP. - 900, CATON AVE</b>   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 23 1996</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04683

Item 28a, c, Film 732, 2/23/96, 1t

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Erwin Authur Thomassen

2. Date of Death

Month Day Year  
Feb. 17, 1996

3. Time of Death

7:05pm

4a. Facility Name (If not institution, give street and number)

338 Presway Rd.

4b. City, Town, or Location of Death

Timonium

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

108-20-0967

6. Sex

1 ☐ M 2 ☐ F  
X

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Aug. 22, 1926

9. Birthplace (State or Foreign Country)

NEW YORK

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

BALTIMORE

10c. City, Town or Location

TIMONIUM

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

338 Presway Rd.

10f. Zip Code

21093

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: 2/12/5113. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
4+16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Senior Design Engineer

16b. Kind of Business/Industry

Defense

17. Father's Name (First, Middle, Last)

Frederick Thomassen

18. Mother's Name (First, Middle, Maiden Surname)

Lenora Kristine Larsen Wollan

19a. Informant's Name/Relationship (Type, Print)

Mrs. Morey Thomassen

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

338 Presway Rd., Timonium, MD 21093

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metro Crematory, Inc.

Data

20 FEB

20c. Location - City or Town, State

Catonsville, MD

21. Signature of Funeral Service Licensee

Bryan W. Clay  
Bryan W. Clay

22. Name and Address of Facility

Lemmon Funeral Home of Dulaney Valley, Inc.  
10 W. Padonia Rd., Timonium, MD 2109323a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Acute leukemia

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

One year

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Chemotherapy

Due to (or as a consequence of):

5 years

c. Lymphoma

Due to (or as a consequence of):

5 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive heart failure, Insulin dependent diabetes

Atrial fibrillation

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 8 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)  
2/17/9628b. Time of  
injury28c. Injury at  
Work?1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Leon Hwang, M.D.

29c. License number

D7880

29d. Date signed (Month, Day, Year)

2/21/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Leon Hwang, M.D., Johns Hopkins, Wolfe St., Balto., MD

31. Date filed (Month, Day, Year)

FEB 23 1996

32. Registrar's Signature

[Signature]

State  
Registrar

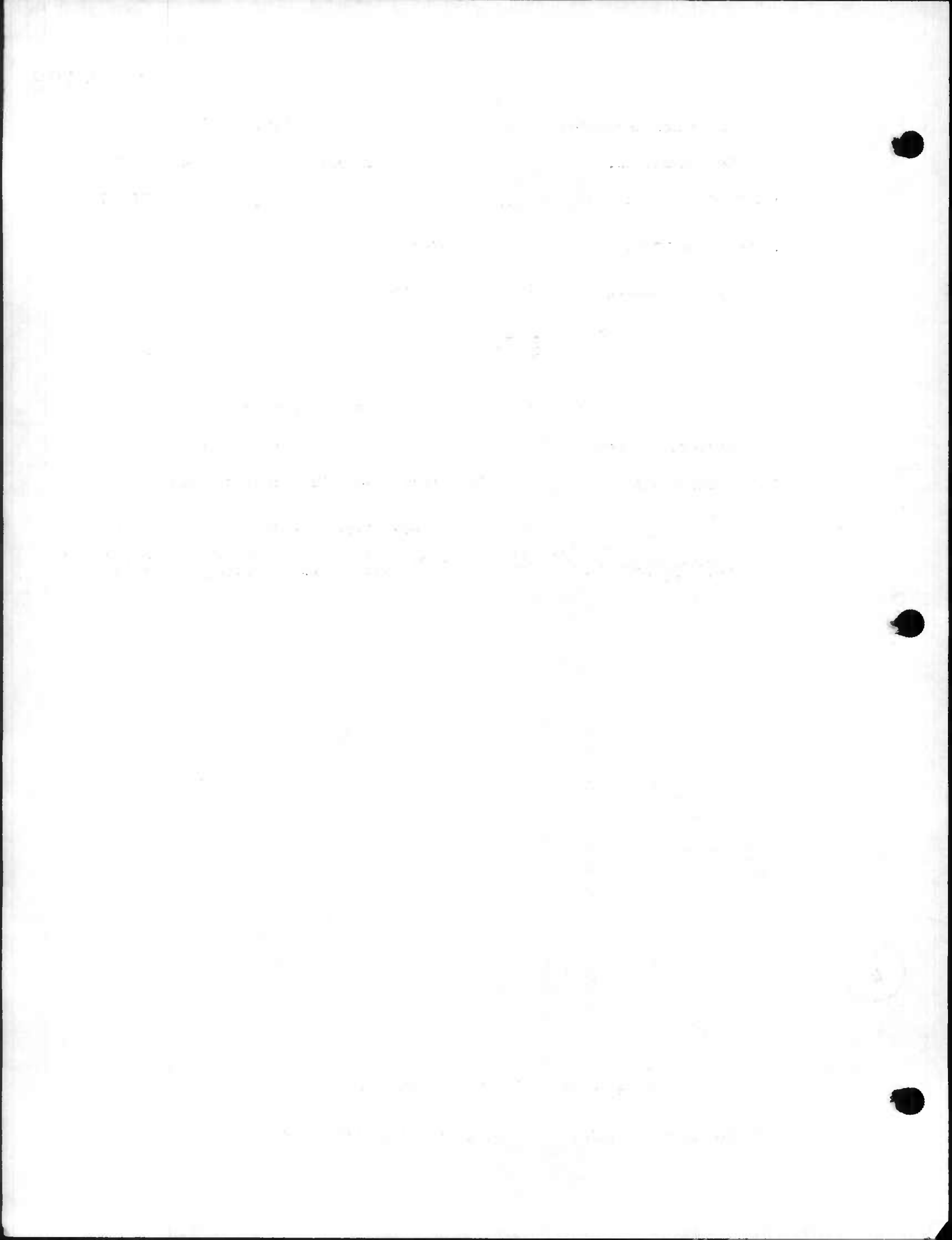
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item 31, Film 732, 2/23/96, 1t

## Certificate of Death

Reg. No.

96 04684

|  |   |  |   |  |  |                                 |   |   |  |   |  |                                      |  |   |  |
|--|---|--|---|--|--|---------------------------------|---|---|--|---|--|--------------------------------------|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Thelma Irene Tracey</b>  |  |   |  | 2. Date of Death<br>Month Day Year<br><b>Feb. 20, 1996</b>   |                                 |   |   | 3. Time of Death<br><b>7 P.M.</b>  |   |  |                                      |  |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Compassionate Care</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>New Windsor</b>   |                                 |   |   | 4c. County of Death<br><b>Carroll</b>  |   |  |                                      |  |   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>215 14 2807</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>82</b> Yrs.   |                                 | 8. Date of Birth (Month, Day, Year)<br><b>July 21, 1913</b> |   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |   |  |                                      |  |   |  |
|  | Usual Residence of Decedent   |  |   |  |  |                                 |   |   |  |   |  |                                      |  |   |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>Md.</b>  |  | 10b. County<br><b>Carroll</b>   |  | 10c. City, Town or Location<br><b>Sykesville</b>   |                                 |   |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   |  |                                      |  |   |  |
|  | 10e. Street and Number<br><b>7526 Dogwood Road</b>  |  |   |  | 10f. Zip Code<br><b>21784</b>  |                                 |   |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   |  |                                      |  |   |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                 |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                            |   |  |                                      |  |   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>---</b>  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Housekeeper</b>  |                                 |   |   | 16b. Kind of Business/Industry<br><b>Springfield Hospital</b>                                      |   |  |                                      |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Sourren Welty</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Rose Mullican</b>  |                                 |   |   |  |   |  |                                      |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Shirley Gartrell</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Box. 195 Union Bridge, Md. 21791</b>   |                                 |   |   |  |   |  |                                      |  |   |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mt. Olivet Cemetery 2/23/96</b>   |                                 |   |   | 20c. Location - City or Town, State<br><b>Frederick, Md.</b>                                       |   |  |                                      |  |   |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Harry W. Haight</b>   |  |   |  | 22. Name and Address of Facility<br><b>Haight Funeral Home<br/>P.O. Box 195 Sykesville, Md. 21784</b>  |                                 |   |   |  |   |  |                                      |  |   |  |
|  | 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. ALZHEIMER'S DISEASE</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |   |  |  |                                 |   |   |  |   | Approximate Interval Between Onset and Death<br><b>5 years</b>   |                                      |  |   |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |                                 |   |   |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |                                      |  |   |  |
|  |   |  |   |  |  |                                 |   |   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |                                      |  |   |  |
|  |   |  |   |  |  |                                 |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |                                      |  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |   |  |  |                                 |   |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                      |  |   |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |   |  |   | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b> |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred   |  |                                      |  |   |  |
|  |   |  |   | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |  |                                 |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                    |  |   |  |                                      |  |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |   |  |  |                                 |   |   |  | 29b. Signature and title of certifier<br><b>Norman Goldstein</b>  |  | 29c. License number<br><b>D26385</b> |  | 29d. Date signed (Month, Day, Year)<br><b>2/22/96</b> |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Norman Goldstein 215 Washington St. Med Ctr Westminster, Md 21107</b>   |   |  |   |  |  |                                 |   |   |  |   |  |                                      |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>2/22/96</b>  |   |  |   | 32. Registrar's Signature<br><b>FEB 23 1996</b>  |  |                                 |   |   |  |   |  |                                      |  |   |  |



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR   |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 96 04685  |  |   |  |
|---|--|--|--|---|--|---|--|---|--|---|--|
| CERTIFICATE OF DEATH  |  |  |  | REG. NO.  |  |   |  |   |  |   |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br>RAYMOND GEORGE WILHELM JR.  |  |  |  | 2. DATE OF DEATH<br>MONTH 2 DAY 14 YEAR 96  |  |   |  | 3. TIME OF DEATH<br>9:00 P M  |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br>220-20-6741  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>67 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>9-4-28   |  | 8. BIRTHPLACE (State or Foreign Country)<br>MARYLAND  |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>638 S. NEWKIRK STREET   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE  |  |   |  | 9c. COUNTY OF DEATH<br>N/A  |  |   |  |
| 10a. STATE<br>MARYLAND  |  |  |  | 10b. COUNTY<br>N/A  |  | 10c. CITY, TOWN OR LOCATION<br>BALTIMORE  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO       |  |   |  |
| 10e. STREET AND NUMBER<br>638 S. NEWKIRK STREET   |  |  |  | 10f. ZIP CODE<br>21224  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  |   |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>WHITE                   |  |   |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 YEARS<br>College (1-4 or 5+) College (1-4 or 5+)   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>CARPET INSTALLER                |  | 16b. KIND OF BUSINESS/INDUSTRY<br>SELF EMPLOYED   |  |   |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>RAYMOND G. WILHELM   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>STELLA   |  |   |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>MR. ROBERT WILHELM  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>126 WEST VIRGINIA AVE. SEVERN, MD. 21144   |  |   |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>GREEN MOUNT CEM. 2-15   |  | 20c. LOCATION — City or Town, State<br>BALTO. MD.   |  |   |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Charles B. Kaczorowski</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>KACZOROWSKI FUNERAL HOME<br>2525 FLEET ST. BALTO. MD. 21224   |  |   |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>ACUTE MYOCARDIAL INFARCTION</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |   |  | Approximate Interval Between Onset and Death<br>SUDDEN  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>HYPERTENSION, HYPERLIPIDEMIA</u>   |  |  |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |  |   |  |   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DCA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Pending Investigation<br>3 <input type="checkbox"/> Accident 4 <input type="checkbox"/> Suicide 5 <input type="checkbox"/> Could not be determined<br>6 <input type="checkbox"/> Homicide   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                      |  |   |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                              |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Irvin B. Kaplan MD</i>  |  |   |  | 29c. LICENSE NUMBER<br>D06776   |  | 29d. DATE SIGNED (Month, Day, Year)<br>2/20/96  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)<br>IRVIN B. KAPLAN, MD 129 S BROADWAY 21231  |  |  |  |   |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>FEB 23 1996  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Romero</i>  |  |   |  |   |  |   |  |





FOR  
1. STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04686

|   |  |  |  |   |  |   |   |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>VERNA ZALOUDEK  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>February 16, 1996   |  | 3. TIME OF DEATH<br>11:40 a <sup>m</sup>  |   |
| 4. SOCIAL SECURITY NUMBER<br>218-09-1720  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 8. AGE (In yrs. last birthday)<br>79 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>April 2, 1916  |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br>RIVERVIEW NURSING CENTRE, INC.  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Essex  |  | 9c. COUNTY OF DEATH<br>Baltimore  |   |
| 10a. STATE<br>Maryland  |  | 10b. COUNTY<br>N/A   |  | 10c. CITY, TOWN OR LOCATION<br>Baltimore  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br>609 North Luzerne Ave<br>EASTERN BLVD BALTIMORE MD.   |  |  |  | 10f. ZIP CODE<br>21221-2105   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                                    |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>10th grade   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Homemaker   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Own Home  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>George Cromwell  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Agnes L. Link  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>Paul Maas (Son)   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>8014 Eastdale Road, Baltimore, Maryland 21224  |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Parkwood Cemetery 2/19/96   |  | 20c. LOCATION — City or Town, State<br>Baltimore, Maryland  |  | 20d. DATE<br>2/19/96  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Robert J. Jodachy  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Schimunek Funeral Home<br>3331 Brehms Lane, Baltimore, Maryland 21213   |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Arteriosclerotic Coronary Vascular Disease</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. _____ DUE TO (OR AS A CONSEQUENCE OF):<br>c. _____ DUE TO (OR AS A CONSEQUENCE OF):<br>d. _____ |  |  |  |   |  |   | Approximate Interval Between Onset and Death<br>yrs.  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Chronic Heart Failure, Chronic Bronchitis, Polymyopathy, Diabetes.</u>   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |   |  |   |   |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  |   |  |   |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO     |   |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  | 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)  |  |   |   |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |
| 29. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |   |
| 29a. SIGNATURE AND TITLE OF CERTIFIER<br>Michael Schwartz   |  |  |  | 29b. LICENSE NUMBER<br>D19677   |  | 29c. DATE SIGNED (Month, Day, Year)<br>2/16/96  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>DR. MICHAEL SCHWARTZ 606 HAMMONDS LANE BALTIMORE, MD. 21225  |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br>FEB 23 1996  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>John Davidson-Randall  |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DHMH-16 Rev 1/89

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked as item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR  |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 96 04688  |  |  |  |
|--|--|--|--|---|--|---|--|---|--|--|--|
| CERTIFICATE OF DEATH   |  |  |  | REG. NO.  |  |   |  |   |  |  |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br>ALMA GRACE ZIEGLER   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>February 19, 1996   |  |   |  | 3. TIME OF DEATH<br>12:45 am M  |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br>236-48-9697   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>72 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>Dec. 7, 1923   |  | 8. BIRTHPLACE (State or Foreign Country)<br>West Virginia   |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>7871 St. Gregory Drive   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Dundalk  |  |   |  | 9c. COUNTY OF DEATH<br>Baltimore  |  |  |  |
| 10a. STATE<br>Maryland   |  |  |  | 10b. COUNTY<br>Baltimore  |  | 10c. CITY, TOWN OR LOCATION<br>Dundalk  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO       |  |  |  |
| 10e. STREET AND NUMBER<br>7871 St. Gregory Drive   |  |  |  | 10f. ZIP CODE<br>21222  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>United States  |  |   |  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>white                             |  |   |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>9 years   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Assembler   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Shoe Manufacturing  |  |   |  |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Roy Ault  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Mary DeBerry   |  |   |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Mr. Alvin Gene Ziegler   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>7871 St. Gregory Dr., Baltimore, MD 21222  |  |   |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Shady Grove Cemetery Feb. 23, 1996  |  | 20c. LOCATION — City or Town, State<br>Brandonville, WV   |  |   |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Brian T. Chisholm   |  | 22. NAME AND ADDRESS OF FACILITY<br>Duda-Ruck Funeral Home of Dundalk, Inc.<br>7922 Wise Avenue, Baltimore, MD 21222   |  |   |  |   |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. Metastatic Endometrial Carcinoma<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>Cardiorespiratory Arrest<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |   |  | Approximate Interval Between Onset and Death  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  |   |  |   |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, tectory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>William C. Shubert M.D.   |  |  |  |   |  | 29c. LICENSE NUMBER<br>220637   |  | 29d. DATE SIGNED (Month, Day, Year)<br>Feb 19, 1996   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Francis C. Crumrine, 6569 N. Charles St., Towson Md, 21204  |  |  |  |   |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>FEB 23 1996   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>[Signature]  |  |   |  |   |  |  |  |



## Certificate of Death

Reg. No.

96 04689

|  |   |  |  |   |  |   |   |  |
|--|---|--|--|---|--|---|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>ROBERT WILLIAM ACKERMAN</b>  |  |  |   | 2. Date of Death<br>Month <b>FEBRUARY</b> Day <b>11</b> Year <b>1996</b>   |   | 3. Time of Death<br><b>11:40 PM</b>                                     |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>SACRED HEART HOSPITAL</b>  |  |  |   | 4b. City, Town, or Location of Death<br><b>CUMBERLAND</b>  |   | 4c. County of Death<br><b>ALLEGANY</b>                                  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>163-12-7748</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>79</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>Jan 28, 1917</b>              | 9. Birthplace (State or Foreign Country)<br><b>PA.</b>   |
|  | Usual Residence of Decedent   |  |  |   |  |   |   |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>PA</b>   |  | 10b. County<br><b>Somerset</b>   |   | 10c. City, Town or Location<br><b>RD 4 Meyersdale</b>  |   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
|  | 10e. Street and Number<br><b>RD4</b>  |  |  |   | 10f. Zip Code<br><b>15552</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>                             |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>43-45</b> |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4or 5+)  |  |  |   | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Salesman</b>   |   | 16b. Kind of Business/Industry<br><b>Building Materials</b>             |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Eson Ackerman</b>   |  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Marie Saylor</b>   |   |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Leoda K. Ackerman</b>  |  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>RD 4 Meyersdale, Pa. 15552</b>   |   |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Union Cemetery</b>  |   | Date<br><b>2/14/96</b>   |   | 20c. Location - City or Town, State<br><b>Meyersdale, PA 15552</b>      |  |
|  | 21. Signature of Funeral Service Licensee<br><b>M. Ray Leckemby</b>   |  | 22. Name and Address of Facility<br><b>M. Ray Leckemby Funeral Home<br/>203 North St Meyersdale, Pa. 15552</b>   |   |  |   |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><b>MULTIPLE INJURIES</b><br>e. Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |  |   |  |   |   |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |  |   |  |   |   |  |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |  |   |  |   |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |  |   |  |   |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |  |  |   |  |   |   |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |  |   |  |   |   |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |   |  |  |   |  |   |   |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide  |   | 28a. Date of Injury (Month, Day, Year)<br><b>2-11-96</b> |  | 28b. Time of Injury<br><b>P M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   | 28d. Describe how injury occurred<br><b>DRIVER OF AUTO VS AUTO COLLISION</b>                   |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>STREET</b>  |   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>NATIONAL PIKE &amp; FINZEL ROAD GARRETT CO., MD.</b> |  |   |   |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |  |   |  |   |   |  |
| 29b. Signature and title of certifier<br><b>[Signature]</b>  |   |  |  | 29c. License number<br><b>O.C.M.E.</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>FEBRUARY 12, 1996</b>                             |   |  |
| 30. Name and address of person who completed cause of death (Form 23a) (Type, Print)<br><b>MARIO F. GOLW JK MD 111 Penn Street, Baltimore, Maryland 21201</b>  |   |  |  |   |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 21 1996</b>  |   |  |  | 32. Registrar's Signature<br><b>[Signature]</b>   |  |   |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

282,10



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 04690

|   |  |  |   |  |   |  |                                |  |  |  |  |  |   |  |  |  |
|---|--|--|---|--|---|--|--------------------------------|--|--|--|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Thomas Theodore Anderson</b>  |  |   |  | 2. Date of Death<br>Month <b>Jan.</b> Day <b>20</b> Year <b>1996</b>  |  |                                |  | 3. Time of Death<br><b>12:35PM</b>   |  |  |  |   |  |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Memorial Hospital @ Easton</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Easton</b>   |  |                                |  | 4c. County of Death<br><b>Talbot</b>   |  |  |  |   |  |  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>214-58-3417</b>  |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>43</b> Yrs.  |  | If Under 1 Year<br>Months Days |  | If Under 24 Hrs.<br>Hours Min.   |  | 8. Date of Birth (Month, Day, Year)<br><b>May 19, 1952</b>     |  | 9. Birthplace (State or Foreign Country)<br><b>Illinois</b> |  |  |  |
|   | Usual Residence of Decedent  |  |   |  |   |  |                                |  |  |  |  |  |   |  |  |  |
| To Be Completed by Funeral Director           | 10a. State<br><b>MD.</b>   |  | 10b. County<br><b>Talbot</b>  |  | 10c. City, Town or Location<br><b>Easton</b>  |  |                                |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |  |   |  |  |  |
|   | 10e. Street and Number<br><b>28 S. Washington Street</b>   |  |   |  | 10f. Zip Code<br><b>21601</b>   |  |                                |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |  |  |   |  |  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  |                                |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |  |  |   |  |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> Collage (1-4 or 5+) <b>Collage</b>  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Radio Announcer</b>   |  |                                |  | 16b. Kind of Business/Industry<br><b>Broadcasting</b>  |  |  |  |   |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Theodore Martin Anderson</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Amelia Kurpuweit</b>  |  |                                |  |  |  |  |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) ExWife<br><b>Pamela DeM. Anderson</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>329 South Carolina Rd., Stevensville, Md. 21666</b>   |  |                                |  |  |  |  |  |   |  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Oxford Cemetery</b>  |  |                                |  | Data<br><b>Jan. 24, 1996</b>   |  | 20c. Location - City or Town, State<br><b>Easton, Maryland</b> |  |   |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>Tom Helfenbein Funeral Homes, P.A.<br/>106 Shamrock Rd., Chester, Md. 21619</b>  |  |                                |  |  |  |  |  |   |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediata Cause (Final disease or condition resulting in death)<br><br>a. <b>HEPATO-RENAL SYNDROME</b><br>Dua to (or as a consequence of):<br><br>b. <b>CIRRHOSIS OF THE LIVER</b><br>Dua to (or as a consequence of):<br><br>c.<br>Dua to (or as a consequence of):<br><br>d.<br>Dua to (or as a consequence of):<br><br>Approximate Interval Between Onset and Death<br><br>3 weeks<br><br>6 months |  |   |  |   |  |                                |  |  |  |  |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><b>COAGULOPATHY</b><br><br><b>Esophageal Varices</b><br><br><b>Alcohol Dependence</b>  |  |   |  |   |  |                                |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |  |   |  |  |  |
|   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |                                |  |  |  |  |  |   |  |  |  |
|   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                |  |  |  |  |  |   |  |  |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  |   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M       |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred                              |  |   |  |  |  |
| State Registrar                               | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  | 29b. Signature and title of certifier<br>   |  |                                |  | 29c. License number<br><b>D40200</b>   |  |  |  | 29d. Date signed (Month, Day, Year)<br><b>1-20-96</b>       |  |  |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Allan Anderson, MD, #1 Mill Place, Easton, Md. 21601</b>  |  |   |  |   |  |                                |  |  |  |  |  |   |  |  |  |
|   | 31. Date filed (Month, Day, Year)<br><b>01/23/96</b>   |  |   |  | 32. Registrar's Signature<br>   |  |                                |  |  |  |  |  |   |  |  |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 01691

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Joyce Ann Baynard

2. Date of Death

Month Day Year  
Jan 29 1996

3. Time of Death

9:25 PM

4a. Facility Name (If not institution, give street and number)

Memorial Hospital at Easton

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

Funeral  
Director

5. Social Security Number

217-42-5886

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

50 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 22, 1945

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Delaware

10b. County

Kent

10c. City, Town or Location

Dover

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

35 Ann Ave.

10f. Zip Code

19904

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2 years

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Open Community Counselor

16b. Kind of Business/Industry

St. Benedict School

17. Father's Name (First, Middle, Last)

Walter

S. Harris

18. Mother's Name (First, Middle, Maiden Surname)

Thelma

R.

Harris

19a. Informant's Name/Relationship (Type, Print)

Kathleen Fletcher

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6 Clarence Street, Dover, De. 19904

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Spring Grove Cemetery

Date

2/5/96

20c. Location - City or Town, State

Denton, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Bennie Smith Funeral Home

P.O. Box 1687, Easton, Maryland 21601

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Adenocarcinoma small bowel

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

9 months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D38887

29d. Date signed (Month, Day, Year)

1/30/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David H. Smith, M.D., 509 Idlewild Ave, Easton, Maryland 21601

31. Date filed (Month, Day, Year)

FEB 07 1996

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR   |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 96 04692  |  |   |  |   |  |
|---|--|--|--|--|--|--|--|---|--|---|--|---|--|
| CERTIFICATE OF DEATH  |  |  |  | REG. NO.   |  |  |  |   |  |   |  |   |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>LILLIAN SMITH BYRNE</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>FEBRUARY 6 1996</b>   |  |  |  | 3. TIME OF DEATH<br><b>11:30 A M</b>  |  |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>058-38-7467</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>91</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS                     |  | IF UNDER 24 HRS.<br>HOURS MIN.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>APRIL 1, 1904</b> |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>OHIO</b> |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>MEDPointe</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>ELKTON</b>   |  |  |  | 9c. COUNTY OF DEATH<br><b>CECIL</b>   |  |   |  |   |  |
| RESIDENCE OF DECEDENT   |  |  |  |  |  |  |  |   |  |   |  |   |  |
| 10a. STATE<br><b>MARYLAND</b>   |  | 10b. COUNTY<br><b>CECIL</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>ELKTON</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |   |  |   |  |
| 10e. STREET AND NUMBER<br><b>#1 Price Drive</b>   |  |  |  | 10f. ZIP CODE<br><b>21921</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                             |  |   |  |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>College</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>                   |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Homemaker</b> |  |   |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>WALTER SMITH</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>ELIZABETH MERREN</b>   |  |  |  |   |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>EDWARD R. BYRNE</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1 Est. Court Madison New Jersey 07940</b>  |  |  |  |   |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>RA Ferns crem. FEB 7 1996</b>                              |  | 20c. LOCATION — City or Town, State<br><b>Westchester PA.</b>  |  |  |  |   |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Edward M. McKown U.P.</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>GEC FUNERAL HOME 259 E. MAIN ST. ELKTON MD</b>  |  |  |  |   |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Pneumonia</b><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Approximate interval Between Onset and Death<br><b>84 hrs</b> |  |  |  |  |  |  |  |   |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Organic Brain Syndrome</b>   |  |  |  |  |  |  |  |   |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |  |  |  |  |   |  |   |  |   |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |  |  |  |  |   |  |   |  |   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  |  |  |  |  |   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |   |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M                           |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  | 28d. DESCRIBE HOW INJURY OCCURRED                           |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Loehders MD</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D23382</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>2/6 1996</b>      |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>S.S. SARHDEV MD. 118 North St Suite 3B, ELKTON MD 21921.</b>  |  |  |  |  |  |  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 07 1996</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>John Davidson Randall</b>  |  |  |  |   |  |   |  |   |  |



96 04693

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>EDWIN H. BARNES</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH <b>2</b> DAY <b>10</b> YEAR <b>96</b>   |  | 3. TIME OF DEATH<br><b>7:30 A.M.</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>212-38-4463</b>  |  | 5. SEX<br><b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>87</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>4 26 08</b>  |  |
| 8a. FACILITY NAME (If not institution, give street and number)<br><b>College Manor</b>   |  |   |  | 8b. CITY, TOWN OR LOCATION OF DEATH<br><b>Lutherville</b>   |  | 8c. COUNTY OF DEATH<br><b>Baltimore</b>  |  |
| RESIDENCE OF DECEDENT  |  |   |  |   |  |  |  |
| 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY<br><b>Baltimore</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Lutherville</b>   |  | 10d. INSIDE CITY LIMITS?<br><b>1</b> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>300 West SEMINARY AVE.</b>  |  |   |  | 10f. ZIP CODE<br><b>21093</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 11. MARITAL STATUS<br><b>3</b> <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                                  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>5+</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Supervisor Pupil Services</b>     |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>EDUCATION</b>  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>HARRY BARNES</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>ELIZABETH L. HELBIG</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>NANCY S. BARNES</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3 SALT HILL CT. Timonium MD 21093</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><b>1</b> <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Hopewell Cemetery 2/13/96</b>                                   |  | 20c. DATE<br><b>2/13/96</b>   |  | 20d. LOCATION — City or Town, State<br><b>Rising Sun, MD</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>[Signature]</b>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Gee Funeral Home.<br/>254 E. Main St. ELKTON, MD. 21921</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Probable myocardial infarction</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>Coronary artery disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br><b>20 years</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br><b>20 years</b> |  |   |  |   |  |  | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>congestive heart failure</b><br><b>dementia</b>   |  |   |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><b>1</b> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1</b> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  |   |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA<br>OTHER: <b>4</b> <input checked="" type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify) |
| 27. MANNER OF DEATH<br><b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation<br><b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined<br><b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><b>1</b> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  | 29a. CERTIFIER<br>(Check only one)<br><b>1</b> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>[Signature]</b>  |  |   |  | 29c. LICENSE NUMBER<br><b>024732</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>2/12/96</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>515 Fairmount Ave St. 300 Towson 21286</b>   |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>2/12/96</b>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><b>FEB 14 1996 Julia Davidson Randall</b>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04694

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ANTHONY V. BAUTISTA

2. Date of Death

FEB. 10, 1996

3. Time of Death

0430AM

4a. Facility Name (If not institution, give street and number)

BILLINGSLEY ROAD

4b. City, Town, or Location of Death

WALDORF

4c. County of Death

CHARLES

Funeral  
Director

5. Social Security Number

217-02-2183

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

29

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

SEPT. 22, 1966

9. Birthplace (State or Foreign Country)

WASHINGTON, DC

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

CHARLES

10c. City, Town or Location

WHITE PLAINS

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9900 HOPE ACRES RD.

10f. Zip Code

20695

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

ELECTRICIAN

16b. Kind of Business/Industry

ELECTRICAL CONTRACTOR

17. Father's Name (First, Middle, Last)

RUDY V. BAUTISTA

18. Mother's Name (First, Middle, Maiden Surname)

ROBERTA J. GORDNER

19a. Informant's Name/Relationship (Type, Print)

RUDY V. BAUTISTA/ FATHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9900 HOPE ACRES RD. WHITE PLAINS, MARYLAND 20695

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

TRINITY MEMORIAL GARDENS

Date

2/14/96

20c. Location - City or Town, State

WALDORF, MARYLAND

21. Signature of Funeral Service Licensee

BENJAMIN M. MATTHEWS M-00658

22. Name and Address of Facility

THE HUNTT FUNERAL HOME, INC  
P.O. BOX 156 WALDORF, MARYLAND 20604

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MULTIPLE TRAUMAS  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

XX Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence

XX Other (Specify) ROADWAY

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation  
2 ☒ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

2 10 96

28b. Time of Injury

0344 AM

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

FIXED OBJECT DRIVER OF CAR IN IMPACT WITH

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

ROADWAY

28f. Location (Street and Number or Rural Route Number, City or Town, State)

BILLINGSLEY ROAD CHARLES CO MD

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.  
XX ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

M. J. Matthews

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

FEB. 10, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

M. J. Matthews 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

FEB 13 1996

32. Registrar's Signature

John Davidson Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04695

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

PEARL VIRGINIA BENNETT

2. Date of Death

Month Day Year  
FEBRUARY 2, 1996

3. Time of Death

10:15 PM

4a. Facility Name (If not institution, give street and number)

Annapolis Nursing &amp; Rehabilitation Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

5. Social Security Number

219-26-3013

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
June 2, 1914

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State  
Maryland10b. County  
Anne Arundel10c. City, Town or Location  
Annapolis

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

110 Edelman Drive

10f. Zip Code

21403

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Bookkeeper

16b. Kind of Business/Industry

Banking

17. Father's Name (First, Middle, Last)

Harvey Cummings

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Bull

19a. Informant's Name/Relationship (Type, Print)

Carla B. Rosenfeld/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

110 Edelman Drive, Annapolis, Maryland 21403

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hillcrest Cemetery

Date

2-5-96

20c. Location - City or Town, State

Annapolis, Maryland

21. Signature of Funeral Service Licensee

Wayne J. Budy

22. Name and Address of Facility

John M. Taylor Funeral Home, Inc., 147 Duke of Gloucester St., Annapolis, Maryland 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Sepsis

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5 mos

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. osteomyelitis - sacrum

Due to (or as a consequence of):

5 mos

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Susan Krieger, MD

29c. License number

D44838

29d. Date signed (Month, Day, Year)

2-6-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. KRIEGER, MD 134 Owensville Rd West River, MD 20778

31. Date filed (Month, Day, Year)

FEB 08 1996

32. Registrar's Signature

Dorothy Randall

State  
Registrar

20720 20

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR   |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 96 04696  |  |
|---|--|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR   |  |   |  | 3. TIME OF DEATH  |  |
| VIRGINIA C. BRUNO   |  |  |  | FEBRUARY 4, 1996   |  |   |  | 11:25 P M   |  |
| 4. SOCIAL SECURITY NUMBER   |  | 5. SEX   |  | 6. AGE (In yrs. last birthday)   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)                                  |  | 8. BIRTHPLACE (State or Foreign Country)  |  |
| 578-10-4010   |  | 1 M 2 F  |  | 78 YRS.  |  | JULY 25 1917  |  | GEORGIA   |  |
| 9a. FACILITY NAME (If not Institution, give street and number)  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH  |  |   |  | 9c. COUNTY OF DEATH   |  |
| ANNE ARUNDEL MEDICAL CENTER   |  |  |  | ANNAPOLIS  |  |   |  | ANNE ARUNDEL  |  |
| RESIDENCE OF DECEDENT   |  |  |  |  |  |   |  |   |  |
| 10a. STATE  |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION  |  | 10d. INSIDE CITY LIMITS?  |  |   |  |
| MD  |  | ANNE ARUNDEL   |  | EDGEWATER  |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |   |  |
| 10e. STREET AND NUMBER  |  |  |  | 10f. ZIP CODE  |  | 10g. CITIZEN OF WHAT COUNTRY?   |  |   |  |
| 1628 MIDLAND ROAD   |  |  |  | 21037  |  | UNITED STATES   |  |   |  |
| 11. MARITAL STATUS  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN?   |  | 14. RACE — American Indian, Black, White, etc.                          |  |   |  |
| 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>Specify:  |  | Specify: WHITE  |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)  |  |  |  | 18a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |
| Elementary/Secondary (0-12) 12 College (1-4 or 5 +)   |  |  |  | HOMEMAKER  |  | HOME  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)  |  |   |  |   |  |
| ARTHUR EDWARD CALLIES   |  |  |  | FLETA VIRGINIA KELLY   |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)  |  |   |  |   |  |
| JAMES MICHAEL BRUNO   |  |  |  | 19408 RENA COURT BROOKEVILLE, MARYLAND 20833   |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)                      |  | DATE   |  | 20c. LOCATION — City or Town, State                                     |  |   |  |
| 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 11. LINCOLN CEMETERY   |  | 2/7/96   |  | BRENTWOOD, MARYLAND   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE   |  |  |  | 22. NAME AND ADDRESS OF FACILITY   |  |   |  |   |  |
| <i>Donald A. Lupton</i>   |  |  |  | JOHN M. TAYLOR FUNERAL HOME<br>147 DUKE OF GLOUCESTER ST. ANNAPOLIS, MD  |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |  |  |  |  |   |  | Approximate Interval Between Onset and Death  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Metastatic Colon Cancer</i>  |  |  |  |  |  |   |  | 1 year  |  |
| Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  |  |  |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>   |  |  |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)  |  |   |  |   |  |
|   |  |  |  | HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY  |  | 28c. INJURY AT WORK?  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
| 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  |  |  | M  |  | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO            |  |   |  |
| 29a. CERTIFIER (Check only one)   |  |  |  | 29c. LICENSE NUMBER  |  |   |  |   |  |
| 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  | 29d. DATE SIGNED (Month, Day, Year)  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER   |  |  |  | 29d. DATE SIGNED (Month, Day, Year)  |  |   |  |   |  |
| <i>R. I. Hochman MD</i>   |  |  |  | 2/5/96   |  |   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)   |  |  |  |  |  |   |  |   |  |
| <i>R. I. Hochman MD - 1833 A Forest Dr. Annapolis, Md. 21401</i>  |  |  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)   |  |  |  | 32. REGISTRAR'S SIGNATURE  |  |   |  |   |  |
| FEB 08 1996   |  |  |  | <i>John A. ...</i>   |  |   |  |   |  |

20270

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR  |  |   |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 96 04697                          |  |
|--|--|---|--|---|--|---|--|-----------------------------------|--|
| CERTIFICATE OF DEATH   |  |   |  | REG. NO.  |  |   |  |                                   |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>S. ANGELA BURKE</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>FEBRUARY 7 1996</b>  |  | 3. TIME OF DEATH<br><b>1:10A M</b>  |  |                                   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>095-30-9215</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 6. AGE (In yrs. last birthday)<br><b>88</b> YRS. | 7. DATE OF BIRTH (Month, Day, Year)<br><b>OCT 28 1907</b>   |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>IRELAND</b>  |  |                                   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>3116 STONEHENGE DRIVE</b>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>RIVA</b>  |  | 9c. COUNTY OF DEATH<br><b>ANNE ARUNDEL</b>  |  |                                   |  |
| 10a. STATE<br><b>MD</b>  |  | 10b. COUNTY<br><b>ANNE ARUNDEL</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>CROFTON</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |                                   |  |
| 10e. STREET AND NUMBER<br><b>1638 DRYDEN WAY</b>   |  |   |  | 10f. ZIP CODE<br><b>21114</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>UNITED STATES</b>   |  |                                   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  |                                   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>3</b> College (1-4 or 5+) <b>3</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>REGISTERED NURSE</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>HEALTH CARE</b>  |  |   |  |                                   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>WILLIAM RYAN</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>ALICE KERR</b>  |  |   |  |                                   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>BRIAN T. BURKE, SON</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3116 STONEHENGE DRIVE RIVA, MARYLAND 21140</b>  |  |   |  |                                   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>ST. MARYS CEMETERY 2/13/96</b>  |  | 20c. LOCATION — City or Town, State<br><b>YONKERS, NEW YORK</b>   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>JOHN M. TAYLOR FUNERAL HOME, 147 DUKE OF GLOUCESTER ST. ANNAPOLIS, MD</b>                        |  |                                   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b><br><b>Myocardial ischemia</b><br><b>Due to (or as a consequence of):</b><br><b>anemia</b><br><b>Rectal Carcinoma</b><br><b>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b><br><b>Rectal Carcinoma</b> |  | Approximate interval between Onset and Death<br><b>2h</b><br><b>3 min</b><br><b>6 mos</b>   |  |   |  |   |  |                                   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>NONE KNOWN -</b>  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |                                   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |   |  |   |  |   |  |                                   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |                                   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Donald A. Lytle</b>   |  | 29c. LICENSE NUMBER<br><b>D21438</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>2/7/96</b>  |  |                                   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>MICHAEL J. LAURENZA MD LOWRIGLEY AESTHEM ANNAPOLIS MD 21401</b>  |  |   |  |   |  |   |  |                                   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 09 1996</b>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><b>John Andrew Parrott</b>   |  |   |  |                                   |  |

1000-100

1000-100



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR  |  |   |                                | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 96 04698  |  |  |  |
|---|--|---|--------------------------------|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)  |  |   |                                | 2. DATE OF DEATH  |  |  |  | 3. TIME OF DEATH  |  |  |  |
| ESTHER H. BROWN   |  |   |                                | February 8, 1996  |  |  |  | 04:05 AM  |  |  |  |
| 4. SOCIAL SECURITY NUMBER   |  | 5. SEX  | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR   |  | IF UNDER 24 HRS.   |  | 7. DATE OF BIRTH  |  | 8. BIRTHPLACE (State or Foreign Country) |  |
| 215-38-0095   |  | 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 93 YRS.                        | MONTHS DAYS   |  | HOURS MIN.   |  | JAN. 2 1903   |  | PENNSYLVIA                               |  |
| 9a. FACILITY NAME (If not institution, give street and number)  |  |   |                                | 9b. CITY, TOWN OR LOCATION OF DEATH   |  |  |  | 9c. COUNTY OF DEATH   |  |  |  |
| ANNE ARUNDEL MEDICAL CENTER   |  |   |                                | ANNAPOLIS   |  |  |  | ANNE ARUNDEL  |  |  |  |
| RESIDENCE OF DECEDENT   |  |   |                                | 10c. CITY, TOWN OR LOCATION   |  |  |  | 10d. INSIDE CITY LIMITS?  |  |  |  |
| 10a. STATE  |  | 10b. COUNTY   |                                | CENTERVILLE   |  |  |  | <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO       |  |  |  |
| MARYLAND  |  | QUEEN ANNE  |                                |   |  |  |  |   |  |  |  |
| 10e. STREET AND NUMBER  |  |   |                                | 10f. ZIP CODE   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?   |  |  |  |
| 801 CHURCH HILL ROAD  |  |   |                                | 21617   |  |  |  | US  |  |  |  |
| 11. MARITAL STATUS  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?   |                                | 13. WAS DECEDENT OF HISPANIC ORIGIN?  |  | 14. RACE — American Indian, Black, White, etc.               |  |   |  |  |  |
| 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES          |                                | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>Specify:   |  | Specify:   |  | BLACK   |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.) |                                | 16b. KIND OF BUSINESS/INDUSTRY  |  |  |  |   |  |  |  |
| Elementary/Secondary (0-12)<br>12th   |  | College (1-4 or 5 +)<br>4 yrs.  |                                | TEACHER   |  | QUEEN ANNE BOARD OF EDUCATION                                |  |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)   |  |   |                                | 18. MOTHER'S NAME (First, Middle, Maiden Surname)   |  |  |  |   |  |  |  |
| FRED B. ALLEN   |  |   |                                | MARY J. LANE  |  |  |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)  |  |   |                                | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)   |  |  |  |   |  |  |  |
| MARVIN J. BROWN   |  |   |                                | 801 CHURCH HILL RD. CENTERVILLE, MD. 21617  |  |  |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)                               |                                | DATE  |  | 20c. LOCATION — City or Town, State                          |  |   |  |  |  |
| <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | CHESTERFIELD CEMETERY   |                                | 2/13/96   |  | CENTERVILLE, MD.   |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE   |  |   |                                | 22. NAME AND ADDRESS OF FACILITY  |  |  |  |   |  |  |  |
| Larry H. Reese  |  |   |                                | REESE & SONS MORTUARY, P.A.<br>821 WEST ST. ANNAPOLIS, MD. 21401  |  |  |  |   |  |  |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |                                |   |  |  |  | Approximate Interval Between Onset and Death                                |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →   |  |   |                                |   |  |  |  | 2 yr  |  |  |  |
| a. <u>Acute Myocardial Infarction</u>   |  |   |                                |   |  |  |  |   |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |   |                                |   |  |  |  |   |  |  |  |
| b. <u>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</u>  |  |   |                                |   |  |  |  |   |  |  |  |
| c. <u>Coronary artery disease</u>   |  |   |                                |   |  |  |  |   |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |   |                                |   |  |  |  |   |  |  |  |
| d. <u>Arteriosclerosis</u>  |  |   |                                |   |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |                                |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?  |  |  |  |
| <u>Coronary artery disease</u>  |  |   |                                |   |  |  |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO     |  |  |  |
| <u>Arteriosclerosis</u>   |  |   |                                |   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |  |  |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |   |                                |   |  |  |  | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?  |  |   |                                | 26. PLACE OF DEATH (Check only one)   |  |  |  |   |  |  |  |
| 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |   |                                | HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |   |  |  |  |
| 27. MANNER OF DEATH   |  | 28a. DATE OF INJURY   |                                | 28b. TIME OF INJURY   |  | 28c. INJURY AT WORK?   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  |
| 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident<br>3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide |  | (Month, Day, Year)  |                                | M   |  | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |   |  |  |  |
|   |  | 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                        |                                | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |  |  |
|   |  |   |                                |   |  |  |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)   |  |   |                                | 29b. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |  |
| 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |                                |   |  |  |  |   |  |  |  |
| 29c. SIGNATURE AND TITLE OF CERTIFIER   |  |   |                                | 29d. LICENSE NUMBER   |  |  |  | 29e. DATE SIGNED (Month, Day, Year)   |  |  |  |
| Gary Spruill MD   |  |   |                                | 032036  |  |  |  | 2/8/96  |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)   |  |   |                                |   |  |  |  |   |  |  |  |
| Gary Spruill 2108 D. Donohue Drive Choke, MD 21619  |  |   |                                |   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)   |  |   |                                | 32. REGISTRAR'S SIGNATURE   |  |  |  |   |  |  |  |
| FEB 09 1996   |  |   |                                | John H. B. B. B.  |  |  |  |   |  |  |  |



96 04699

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>SHANE Francisco Brinkley</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JAN 4-96</b>   |  | 3. TIME OF DEATH<br><b>1412 M</b>                                       |  |
| 4. SOCIAL SECURITY NUMBER<br><b>228-17-1771</b>  |  | 5. SEX<br><b>1 M 2 F</b>   |  | 8. AGE (In yrs. last birthday)<br><b>20 YRS.</b>  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Feb 10-75</b>                 |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>821 Dale Rd</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Glen Burnie</b>   |  | 9c. COUNTY OF DEATH<br><b>AA</b>  |  |
| 10a. STATE<br><b>Maryland</b>  |  |  |  | 10b. COUNTY<br><b>Queen Anne's</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Stevensville</b>                      |  |
| 10d. INSIDE CITY LIMITS?<br><b>1 YES 2 NO</b>  |  |  |  | 10e. STREET AND NUMBER<br><b>202 Caroline Road</b>  |  |   |  |
| 10f. ZIP CODE<br><b>21666</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  |
| 11. MARITAL STATUS<br><b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 YES 2 NO</b><br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 YES 2 NO</b>              |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 8</b>                              |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Plumber Helper</b>               |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Construction</b>                   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Frank Duenas</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Sharon Brinkley</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Wilbur Brinkley</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>202 Caroline Rd., Stevensville, Md. 21666</b> |  |   |  |
| 20a. METHOD OF DISPOSITION<br><b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>                          |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Stevensville Cemetery Jan. 8, 1996</b>   |  | 20c. LOCATION — City or Town, State<br><b>Stevensville, Md. 21666</b>   |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Tom Helfenbein</b>      |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>Tom Helfenbein Funeral Homes, P.A. 106 Shamrock Rd., Chester, Md. 21619</b>                   |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Gunshot Wound, Chest</b><br><b>Sequitentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.               |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><b>1 YES 2 NO</b>                     |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1 YES 2 NO</b>                                     |  |  |  |   |  | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1 YES 2 NO</b>         |  |
| 26. MANNER OF DEATH<br><b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</b>            |  | 27. DATE OF INJURY (Month, Day, Year)<br><b>JAN 4-96</b>   |  | 28a. TIME OF INJURY<br><b>12 Noon</b>   |  | 28b. INJURY AT WORK?<br><b>1 YES 2 NO</b>                               |  |
| 28c. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>Home</b>                                |  | 28d. DESCRIBE HOW INJURY OCCURED<br><b>Shot self.</b>  |  |   |  |   |  |
| 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>Glen Burnie, Md.</b>                              |  | 29a. CERTIFIER (Check only one)<br><b>1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b><br><b>2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>William P. Jones, MD Deputy</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D08054</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>JAN 4-96</b>                  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>William P. Jones, MD 695 America 21035</b> |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>JAN 5 1996</b>   |  | 32. REGISTRAR'S SIGNATURE<br><b>John Brinkley</b>  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR  |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 96 04700  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|---|--|---|--|--|--|
| CERTIFICATE OF DEATH   |  |  |  | REG. NO.  |  |  |  |   |  |   |  |  |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Mildred Grace Butler   |  |  |  | 2. DATE OF DEATH<br>MONTH January DAY 16 YEAR 1996  |  |  |  | 3. TIME OF DEATH<br>2353 P M  |  |   |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br>214-52-0460   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>83 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>Feb. 1, 1912  |  | 8. BIRTHPLACE (State or Foreign Country)<br>Delaware |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>The Kent & Queen Anne's Hospital Inc.  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Chestertown MD   |  |  |  | 9c. COUNTY OF DEATH<br>Kent   |  |   |  |  |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |  |  |   |  |   |  |  |  |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Queen Anne's  |  | 10c. CITY, TOWN OR LOCATION<br>Centreville  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO       |  |   |  |  |  |
| 10e. STREET AND NUMBER<br>715 Hayden Road  |  |  |  | 10f. ZIP CODE<br>21617  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |   |  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White  |  |   |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 4 College (1-4 or 5 +)   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Homemaker  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Montgomery Smith  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Janie Deborah McFarland  |  |  |  |   |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Nelson E. Lord (Grandson)  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>715 Hayden Rd., Centreville, Md. 21617   |  |  |  |   |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Chesterfield Cemetery Jan. 20, 1996                           |  |   |  | 20c. LOCATION — City or Town, State<br>Centreville, Md.                              |  |   |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Chad M. Helfenbein  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Tom Helfenbein Funeral Homes, P.A.<br>555 Main St., Church Hill, Md.  |  |  |  |   |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ACUTE MYOCARDIAL INFARCTION<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST {<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |  |  | Approximate Interval Between Onset and Death  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |  |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>  |  |  |  |   |  |  |  |   |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |   |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>John C. Seymour, MD  |  |  |  | 29c. LICENSE NUMBER<br>D-13824  |  | 29d. DATE SIGNED (Month, Day, Year)<br>1-17-96  |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>John C. Seymour, MD; 122 Speer Road, Chestertown, Md. 21620   |  |  |  |   |  |  |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>01/23/96  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>Linda Davidson-Randall   |  |  |  |   |  |   |  |  |  |



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04701

|   |  |  |  |   |   |  |   |   |  |   |  |
|---|--|--|--|---|---|--|---|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Sylvia Theresa Benson</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 31 1996</b>  |   | 3. TIME OF DEATH<br><b>1314 M</b>  |   |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>214-34-7936</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>57</b> YRS.  |   | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Oct. 9, 1938</b>                       |   | 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>PENINSULA REGIONAL MEDICAL CENTER</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>SALISBURY</b>   |   |  | 9c. COUNTY OF DEATH<br><b>WICOMICO</b>  |   |  |   |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Wicomico</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Salisbury</b>   |   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |   |  |   |  |
| 10e. STREET AND NUMBER<br><b>510 Rose Street</b>  |  |  |  | 10f. ZIP CODE<br><b>21801</b>   |   | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>                                    |   |   |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Black</b>                      |   |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>College</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Domestic</b>   |  |   | 16b. KIND OF BUSINESS/INDUSTRY<br><b>None</b> |  |   |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William Cole</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Alice Johnson</b>   |   |  |   |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Burley Benson JR.</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>510 Rose St. Salisbury, Md. 21801</b>   |   |  |   |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Handy Cemetery</b>   |  | DATE<br><b>3/6</b>  |   | 20c. LOCATION — City or Town, State<br><b>Whitehaven, Md.</b>                    |   |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Gladys B. Stewart</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Stewart Funeral Home</b><br><b>821 West Rd. Salisbury, Md. 21801</b>   |   |  |   |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Shock</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><b>Hemorrhage, cancelled</b><br><b>Ruptured Abdominal Aortic Aneurysm</b><br><b>Huge Abdominal Aortic Aneurysm</b> |  |  |  |   |   |  |   | Approximate Interval Between Onset and Death<br><b>2 Hours</b>  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Chronic Cirrhosis, Alcoholism</b>  |  |  |  |   |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  |   |   |  |   |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |   |  |   |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |   | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |   | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |   |  |   |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>[Signature]</b>  |  |   |   | 29c. LICENSE NUMBER<br><b>D37670</b>   |   | 29d. DATE SIGNED (Month, Day, Year)<br><b>2/01/96</b>   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>H. L. M. Evangelista 105 Pine Bluff Rd #6 Salisbury, MD 21801</b>   |  |  |  |   |   |  |   |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 05 1996</b>   |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson Radell</b>  |  |   |   |  |   |   |  |   |  |





TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR  |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 96 04702  |  |   |  |
|--|--|--|--|---|--|--|--|---|--|---|--|
| CERTIFICATE OF DEATH   |  |  |  | REG. NO.  |  |  |  |   |  |   |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br>MARTHA BARTLETT  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>JANUARY 27, 1996  |  |  |  | 3. TIME OF DEATH<br>3:35 PM   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br>203-32-3780   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>92 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>July 8, 1903                                  |  | 8. BIRTHPLACE (State or Foreign Country)<br>Illinois  |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Northampton Manor  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Frederick  |  |  |  | 9c. COUNTY OF DEATH<br>Frederick  |  |   |  |
| 10a. STATE<br>Maryland   |  |  |  | 10b. COUNTY<br>Frederick  |  | 10c. CITY, TOWN OR LOCATION<br>Frederick   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO       |  |   |  |
| 10e. STREET AND NUMBER<br>4317 Buckeystown Pike  |  |  |  | 10f. ZIP CODE<br>21701  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>United States                                       |  |   |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                     |  |   |  |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>College (1-4 or 5+)<br>+4  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Teacher  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Education   |  |  |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>John Harper Minnick   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Lavinia Farrow   |  |  |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Roscoe Bartlett, Jr. son   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4317 Buckeystown Pike Frederick, MD 21701  |  |  |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Resthaven Memorial Gardens 1/30/96  |  | 20c. LOCATION — City or Town, State<br>Frederick, Maryland  |  |  |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Stauffer funeral Homes, P.A.<br>1621 Opossumtown Pike Frederick, MD 21702   |  |  |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive Heart Failure<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. Atherosclerotic Cardiovascular Disease<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Approximate Interval Between Onset and Death<br>23 days<br>25 years |  |  |  |   |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |  |   |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
|  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)         |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Arthur G. Maximo, M.D.  |  |  |  |   |  | 29c. LICENSE NUMBER<br>D-18191   |  | 29d. DATE SIGNED (Month, Day, Year)<br>1-29-96  |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Arthur G. Maximo, M.D. 187 Thorne Johnson Dr. Frederick, MD. 21702  |  |  |  |   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>JAN 31 1996   |  |  |  |   |  | 32. REGISTRAR'S SIGNATURE<br>John Davidson-Randall                                   |  |   |  |   |  |

205/10 20

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 96 04703

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

BETTY Dolores BAUGHER

2. Date of Death  
Month Day Year

JANUARY 22, 1996 1:30 p.m.

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

Funeral  
Director

5. Social Security Number

214-28-5122

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

63 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Sep 16, 1932

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State  
Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7725-A Edgewood Church Road

10f. Zip Code

21702

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

7

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Clothing Factory

16b. Kind of Business/Industry

Assembly

17. Father's Name (First, Middle, Last)

Alfred Franklin Myers Sr

18. Mother's Name (First, Middle, Maiden Surname)

Naomi Beatrice BLANK

19a. Informant's Name/Relationship (Type, Print)

Arthur C. Baugher, Jr (Husband) 7725-A Edgewood Church Rd, Frederick, MD 21702

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Rocky Springs Cemetery Jan 24, 1996 Frederick, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

 MO0706

22. Name and Address of Facility

Keeney &amp; Basford P.A. Funeral Home

106 East Church St, Frederick, MD 21701

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. RECURRENT GASTRIC CA (SIGNET CELL)  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

8 mth

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

① END STAGE CARDIOMYOPATHY

② PNEUMONIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D32171

29d. Date signed (Month, Day, Year)

1/23/96

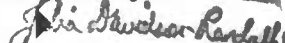
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

R. GOUGH PO Box 328 WALKERSVILLE 21793

31. Date filed (Month, Day, Year)

JAN 24 1996

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "Natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

2000

*[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]*

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. DECEDENT'S NAME (First, Middle, Last)   |  |   |  | 2. DATE OF DEATH   |  |  |  | 3. TIME OF DEATH   |                                     |   |  |
|--|--|---|--|--|--|--|--|--|-------------------------------------|---|--|
| 4. SOCIAL SECURITY NUMBER  |  |   |  | 5. SEX   |  | 6. AGE (In yrs. last birthday)                 |  | 7. DATE OF BIRTH   |                                     | 8. BIRTHPLACE (State or Foreign Country)                                    |  |
| MARY D. BUTLER   |  |   |  | JANUARY 30 1996  |  | 2:00 A M                                       |  |  |                                     |   |  |
| 215-38-7276  |  |   |  | 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 77 YRS.  |  | Sept 15, 1918  |                                     | Maryland  |  |
| 9a. FACILITY NAME (If not institution, give street and number)   |  |   |  | 9b. CITY, TOWN, OR LOCATION OF DEATH   |  |  |  | 9c. COUNTY OF DEATH  |                                     |   |  |
| Southern Maryland Hospital   |  |   |  | Clinton  |  |  |  | PRINCE GEORGE'S  |                                     |   |  |
| 10a. STATE   |  |   |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION                    |  |  |                                     | 10d. INSIDE CITY LIMITS?  |  |
| Maryland   |  |   |  | Prince Georges   |  | Brandywine                                     |  |  |                                     | 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO     |  |
| 10e. STREET AND NUMBER   |  |   |  | 10f. ZIP CODE  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?  |                                     |   |  |
| 16909 Magraders Ferrys Road  |  |   |  | 20613  |  |  |  | U.S.A  |                                     |   |  |
| 11. MARITAL STATUS   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?                             |  | 13. WAS DECEDENT OF HISPANIC ORIGIN?   |  | 14. RACE — American Indian, Black, White, etc. |  |  |                                     |   |  |
| 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married  |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | Specify: Black                                 |  |  |                                     |   |  |
| 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | IF YES, GIVE WAR OR DATES   |  | Specify:   |  |  |  |  |                                     |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)  |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)   |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY   |                                     |   |  |
| Elementary/Secondary (0-12) 12   |  |   |  | College (1-4 or 5+) Home maker   |  |  |  | Domestic   |                                     |   |  |
| 17. FATHER'S NAME (First, Middle, Last)  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)  |  |  |  |  |                                     |   |  |
| James Johnson  |  |   |  | Lucy Fowler  |  |  |  |  |                                     |   |  |
| 19a. INFORMANT'S NAME (Type/Print)   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)  |  |  |  |  |                                     |   |  |
| Phyllis Bell   |  |   |  | 6489 Consic Road Richmond Virginia 23234   |  |  |  |  |                                     |   |  |
| 20a. METHOD OF DISPOSITION   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of place, date, and time)      |  | 20c. LOCATION — City or Town, State  |  |  |  |  |                                     |   |  |
| 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State  |  | St. Philips Episcopal Cemetery Feb 5, 1996                              |  | Baden, Maryland  |  |  |  |  |                                     |   |  |
| 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |   |  |  |  |  |  |  |                                     |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  |  |   |  | 22. NAME AND ADDRESS OF FACILITY   |  |  |  |  |                                     |   |  |
| Lloyd M. Estep   |  |   |  | Adams Funeral Home Agassco Maryland 20608  |  |  |  |  |                                     |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |  |  |  |  |  |                                     | Approximate Interval Between Onset and Death                                |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  |   |  |  |  |  |  |  |                                     | hours   |  |
| a. ACUTE MYOCARDIAL INFARCT  |  |   |  |  |  |  |  |  |                                     |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |  |  |  |  |  |                                     |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST   |  |   |  |  |  |  |  |  |                                     |   |  |
| b. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |  |  |  |  |  |                                     |   |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |  |  |  |  |  |                                     |   |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |  |  |  |  |  |                                     |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  |  |  |  |                                     | 24a. WAS AN AUTOPSY PERFORMED?  |  |
| HYPOXEMIC ENCEPHALOPATHY, CHRONIC ANEMIA   |  |   |  |  |  |  |  |  |                                     | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO     |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |   |  |  |  |  |  |  |                                     | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |  |
|  |  |   |  |  |  |  |  |  |                                     | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?   |  |   |  | 26. PLACE OF DEATH (Check only one)  |  |  |  |  |                                     |   |  |
| 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |   |  | HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |                                     |   |  |
| 27. MANNER OF DEATH  |  |   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY                            |  | 28c. INJURY AT WORK?   |                                     | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
| 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |  |   |  |  |  | M  |  | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                 |                                     |   |  |
|  |  |   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |                                     |   |  |
|  |  |   |  |  |  |  |  |  |                                     |   |  |
| 29a. CERTIFIER (Check only one)  |  |   |  |  |  |  |  |  |                                     |   |  |
| 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |  |  |  |  |  |                                     |   |  |
| 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  |  |  |  |  |                                     |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  |  |   |  |  |  | 29c. LICENSE NUMBER                            |  |  | 29d. DATE SIGNED (Month, Day, Year) |   |  |
| J. BERGER MD   |  |   |  |  |  | D25925   |  |  | Jan 30, 1996                        |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  |  |   |  |  |  |  |  |  |                                     |   |  |
| J. BERGER MD #205 7720 WISCONSIN AVE Bethesda, Md 20814  |  |   |  |  |  |  |  |  |                                     |   |  |
| 31. DATE FILED (Month, Day, Year)  |  |   |  | 32. REGISTRAR'S SIGNATURE  |  |  |  |  |                                     |   |  |
| FEB 07 1996  |  |   |  | John Davidson Randall  |  |  |  |  |                                     |   |  |

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

96 04705

REG. NO.

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>ELLANORA NMN COOK   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>February 1, 1996   |  | 3. TIME OF DEATH<br>3:00 P. M.   |  |
| 4. SOCIAL SECURITY NUMBER<br>214-16-1229  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>75 YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>Aug. 6, 1920  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>346 South Locust Street   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Hagerstown,   |  | 9c. COUNTY OF DEATH<br>Washington  |  |
| RESIDENCE OF DECEDENT   |  |   |  | 10c. CITY, TOWN OR LOCATION<br>Hagerstown  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 10a. STATE<br>Maryland  |  | 10b. COUNTY<br>Washington   |  | 10e. STREET AND NUMBER<br>346 South Locust Street  |  | 10f. ZIP CODE<br>21740   |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>8   |  | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Homemaker   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Own Home   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Frank C. Strasbaugh  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Anna May Groft  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Junior L. Cook  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>346 South Locust St., Hagerstown, Md. 21740   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Green Hill Cemetery 02-05-96   |  | 20c. LOCATION — City or Town, State<br>Waynesboro, Penna.  |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>R. Noel Brady   |  |
| 22. NAME AND ADDRESS OF FACILITY<br>Andrew K. Coffman Funeral Home, Inc.<br>40 E. Antietam St., Hagerstown, Md. 21740   |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. Metastatic Colon Cancer<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  | Approximate interval Between Onset and Death<br>1 year   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |  |
| 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Michael J. McCormack M.D.   |  |
| 29c. LICENSE NUMBER<br>041667   |  | 29d. DATE SIGNED (Month, Day, Year)<br>2-2-96   |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Michael J. McCormack 1799 Howell Rd. Hagerstown, Md. 21740  |  | 31. DATE FILED (Month, Day, Year)<br>FEB 5 1996  |  |
| 32. REGISTRAR'S SIGNATURE<br>John H. ...  |  | 33. ...   |  | 34. ...  |  | 35. ...  |  |





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR   |  |   |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 96 04706  |  |  |  |  |  |
|---|--|---|--|--|--|--|--|---|--|--|--|--|--|
| CERTIFICATE OF DEATH  |  |   |  | REG. NO.   |  |  |  |   |  |  |  |  |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>HEDWIG FRANCESCA CAWL</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>FEBRUARY</b> DAY <b>3</b> YEAR <b>1996</b>  |  |  |  | 3. TIME OF DEATH<br><b>11:30 A M</b>                                    |  |  |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>088-03-2036</b>   |  | 5. SEX<br><b>1 M 2 F</b>  |  | 8. AGE (In yrs. last birthday)<br><b>90</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>                               |  | IF UNDER 24 HRS.<br>HOURS <b></b> MIN. <b></b>                          |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Aug. 31, 1905</b>                               |  | 6. BIRTHPLACE (State or Foreign Country)<br><b>Austria</b>                                       |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Williamsport Nursing Home</b>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Williamsport</b>   |  |  |  | 9c. COUNTY OF DEATH<br><b>Washington</b>                                |  |  |  |  |  |
| RESIDENCE OF DECEDENT   |  |   |  |  |  |  |  |   |  |  |  |  |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Washington</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Hagerstown</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><b>1 X YES 2 NO</b>                         |  |  |  |  |  |
| 10e. STREET AND NUMBER<br><b>925 Beechwood Drive</b>  |  |   |  | 10f. ZIP CODE<br><b>21742</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                             |  |  |  |  |  |
| 11. MARITAL STATUS<br><b>3 X Widowed 4 Divorced</b>   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 YES 2 NO</b><br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 YES 2 X NO</b> Specify:      |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |  |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>12 Elementary/Secondary (9-12)</b>   |  | 15a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>secretary</b>                         |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Fairchild Aircraft</b>  |  |  |  |   |  |  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Unknown</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Unknown</b>  |  |  |  |   |  |  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Kathleen V. Hammer</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>53 Mealey Parkway Hagerstown, Maryland 21742</b> |  |  |  |   |  |  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><b>1 X Burial 2 Cremation 3 Removal from State</b><br><b>4 Donation 5 Other (Specify)</b>   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Rest Haven Cemetery</b>   |  | DATE<br><b>2/8</b>   |  | 20c. LOCATION — City or Town, State<br><b>Hagerstown, Maryland</b>           |  |   |  |  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Gerald N. Minnich</i>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Gerald N. Minnich</b><br><b>Funeral Home</b><br><b>305 N. Potomac Street</b><br><b>Hagerstown, Maryland</b>   |  |  |  |   |  |  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><b>a. ACUTE RENAL FAILURE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. DEHYDRATION</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c. MULTI-INFARCT DEMENTIA</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d.</b> |  |   |  |  |  |  |  |   |  | Approximate Interval Between Onset and Death<br><b>HOURS</b><br><b>DAYS</b><br><b>MONTHS</b> |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>ATRIAL FIBRILLATION, CONGESTIVE HEART FAILURE</b>  |  |   |  |  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><b>1 YES 2 X NO</b>  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1 YES 2 NO</b> |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>   |  |   |  |  |  |  |  |   |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1 YES 2 X NO</b>   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b><br>OTHER: <b>4 X Nursing Home 5 Residence 6 Other (Specify)</b> |  |  |  |  |  |   |  |  |  |  |  |
| 27. MANNER OF DEATH<br><b>1 X Natural 5 Pending Investigation</b><br><b>2 Accident 3 Suicide 6 Could not be determined</b><br><b>4 Homicide</b>   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br><b>1 YES 2 NO</b>                                    |  | 28d. DESCRIBE HOW INJURY OCCURRED                                       |  |  |  |  |  |
|   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |  |   |  |  |  |  |  |
| 29a. CERTIFIER (Check only one)<br><b>1 X CERTIFYING PHYSICIAN:</b> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2 MEDICAL EXAMINER:</b> On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  |  |  |  |   |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>J. Howe M.D.</i>  |  |   |  |  |  | 29c. LICENSE NUMBER<br><b>D33700</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>FEBRUARY 4, 1996</b>          |  |  |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>TED E HOWE</b> <b>154 N ARTIZAN STREET</b> <b>WILLIAMSPORT, MD 21795</b>  |  |   |  |  |  |  |  |   |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 7 1996</b>  |  |   |  |  |  |  |  |   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>J. Howe</i>  |  |

30770 70

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04707

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Clyde Edward Castle

2. Date of Death

Month  
Jan.Day  
30Year  
1996

3. Time of Death

5:15 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

WASHINGTON

5. Social Security Number

213-40-3223

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

53

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Sep. 4, 1942

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

WV

10b. County

Berkeley

10c. City, Town or Location

Falling Waters

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10f. Zip Code

25419

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: 1959-1965

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

X

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Maintenance

16b. Kind of Business/Industry

Local Government

17. Father's Name (First, Middle, Last)

Emmert Cullen Castle

18. Mother's Name (First, Middle, Maiden Surname)

Emma Kate Hull

19a. Informant's Name/Relationship (Type, Print)

Linda D. Castle

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box # 550 Williamsport, MD 21795

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Cedar Lawn Memorial Park

Date

2/2

20c. Location - City or Town, State

Hagerstown, MD 21740

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

OSBORNE FUNERAL HOME

P.O. Box # 348 Williamsport, MD 21795

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Cardiorespiratory Failure

Approximate Interval Between Onset and Death

Few days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of): Adenocarcinoma of Right Lung

Due to (or as a consequence of): with Brain Metastasis

Due to (or as a consequence of):

Few months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pneumonia Bilateral

Arteritis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☐ No

Hospital:

Inpatient

2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D35497

29d. Date signed (Month, Day, Year)

2/1/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TANVIR A. PASHA MD 376 Mill Street HAGERSTOWN MD 21740

31. Date filed (Month, Day, Year)

FEB 1 1996

32. Registrar's Signature

MD 21740

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-d show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

10-20-10



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Amended #16b, 2/9/96, LMG, Talbot

96 04708

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |   |  |   |  |
|--|--|--|--|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Raymond H. Collick</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>2</b> DAY <b>3</b> YEAR <b>96</b>  |  | 3. TIME OF DEATH<br><b>6:00 P.M.</b>  |  |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>214-28-3245</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>76</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>8/29/19</b>                                       |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Ind.</b>   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Snow Hill Nursing &amp; Rehab Center</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Snow Hill, Md</b>   |  |   |  | 9c. COUNTY OF DEATH<br><b>Worcester</b>   |  |   |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Worcester</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Snow Hill</b>   |  |   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO       |  |   |  |
| 10e. STREET AND NUMBER<br><b>301 N. Church St.</b>   |  |  |  | 10f. ZIP CODE<br><b>21863</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>                     |  |   |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4th</b><br>College (1-4 or 5+) <b>Security Guard</b>  |  | 15a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Security Guard</b>       |  | 15b. KIND OF BUSINESS/INDUSTRY<br><b>Security</b>   |  |   |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Olin Collick</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Ada Pitts</b>   |  |   |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Ada Collick</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>742 Doane Ave., Bell Park, New York 11713</b>   |  |   |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Maryland Veterans Cemetery 2/12/96 Beulah, Md.</b>     |  | DATE  |  | 20c. LOCATION — City or Town, State   |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>John A. Prince</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Bennie Smith Funeral Home<br/>426 Dover Street, Easton, Md. 21601</b>  |  |   |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>CACHEXIA + INANITION</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>PROSTATIC CARCINOMA WITH METASTASES</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |   |  | Approximate interval between Onset and Death<br><b>1 month</b><br><b>1 year</b>                       |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>SEIZURE DISORDER</b>  |  |  |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | HOSPITAL:<br><input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA                          |  | 26. PLACE OF DEATH (Check only one)<br>OTHER:<br><input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                   |  |   |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>John A. Prince</b>   |  | 29c. LICENSE NUMBER<br><b>D 5865</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>FEB 3, 1996</b>                                   |  |   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>ROBERT C LAMAR, MD 104 N. BAY ST. SNOW HILL, MD 21863</b>  |  |  |  |   |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 09 1996</b>  |  | 32. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>  |  |   |  |   |  |   |  |   |  |

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96 04709

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>John Dawson Cudmore</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>FEB 06 1996</b>  |  | 3. TIME OF DEATH<br><b>8:48 P<sup>M</sup></b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>219-42-6809</b>  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>51</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Jan. 26, 1945</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>HARFORD MEMORIAL HOSPITAL</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>HAVRE DE GRACE</b>  |  | 9c. COUNTY OF DEATH<br><b>HARFORD</b>   |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Cecil</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Port Deposit</b>  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>1354 Winch Road</b>   |  |  |  | 10f. ZIP CODE<br><b>21904</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                             |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>Twelve Years</b><br>College (1-4 or 5+) <b>-----</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Environmental Engineer</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>V.A. Medical Center<br/>Perry Point, Maryland</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Wilbur E. Cudmore, Sr.</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Eleanor Dawson</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Louise V. Cudmore</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1354 Winch Road, Port Deposit, Maryland 21904</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place)<br><b>Principio Cemetery 2/9/96</b>  |  | 20c. LOCATION — City or Town, State<br><b>Perryville, Maryland</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Thomas M. Patterson, Sr.</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Lee A. Patterson &amp; Son Funeral Home<br/>Perryville, Maryland 21903</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |   | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>  |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br><br>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i> DME  |  |  |  | 29c. LICENSE NUMBER<br><i>OCME</i>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>FEB 07 1996</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Dr. Ganesh Prahbu DME 1810 Belair Road, Fallston, Maryland 21047</b>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 09 1996</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

20240 22

20240 22



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 047110

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ARTHUR JAMES CARTER

2. Date of Death

February 5 1996 8:35 Am

3. Time of Death

Funeral  
Director

4e. Facility Name (If not institution, give street and number)

Prince George's Hospital Center

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

PRINCE GEORGE'S

5. Social Security Number

213-12-3938

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

76

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Sept. 9, 1919 Maryland

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10e. State

Maryland

10b. County

Calvert

10c. City, Town or Location

Huntingtown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

625 Armiger Road

10f. Zip Code

20639

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1944-45

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Postal Clerk

16b. Kind of Business/Industry

U.S. Postal Service

17. Father's Name (First, Middle, Last)

Arthur

Carter

18. Mother's Name (First, Middle, Maiden Surname)

Martha

Kent

19e. Informant's Name/Relationship (Type, Print)

Irving Long/Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

580 Armiger Rd. Huntingtown, MD 20639

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

MD Veterans Cemetery

Date

2/12/96

20c. Location - City or Town, State

Cheltenham, MD

21. Signature of Funeral Service Licensee

Spencer E. Sewell

22. Name and Address of Facility

Sewell Funeral Home

1451 Dares Beach Rd. Prince Frederick, MD 20678

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final  
disease or condition  
resulting in death)

a. CORONARY HEART DISEASE

Due to (or as a consequence of):

years

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Diabetes Mellitus - non-insulin-dependent

Due to (or as a consequence of):

years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension, s/p cardiac pacemaker 2 1/2 yrs.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24e. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

28e. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. Berger MD

29c. License number

D25925

29d. Date signed (Month, Day, Year)

February 6, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. BERGER MD #205, 7720 WISCONSIN AVE, Bethesda, Md 20814

31. Date filed (Month, Day, Year)

FEB - 9 1996

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 24e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |  |   |   |  | REG. NO.  |  |
|--|--|--|--|---|--|--|---|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Bessie Emma Cornwell</b>  |  |  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>02</b> DAY <b>08</b> YEAR <b>1996</b>               |   | 3. TIME OF DEATH<br><b>9:55 A.M.</b>  |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>577 14 6136</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br><b>89</b> YRS. | IF UNDER 1 YEAR<br>MONTHS _____ DAYS _____  |  | IF UNDER 24 HRS.<br>HOURS _____ MIN. _____                                       |   | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>September 19, 1906 Maryland</b>                          |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Calvert County Nursing Center</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Prince Frederick</b>  |  |  | 9c. COUNTY OF DEATH<br><b>Calvert</b>   |   |  |   |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Calvert</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>St. Leonard</b>   |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   |  |   |  |
| 10e. STREET AND NUMBER<br><b>9450 Mackall Road</b>   |  |  |  | 10f. ZIP CODE<br><b>20685</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>                            |   |   |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>white</b>                         |   |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b>   |  | College (1-4 or 5+) _____  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>housewife</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>own home</b>                                |   |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Edward J. Stewart</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Clara Frances</b>   |  |  |   |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Ollie E. Cornwell, Jr.</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2227 Hindel Lane Bowie, Maryland 20716</b>  |  |  |   |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Fort Lincoln February 12, 1996</b>   |  | DATE _____  |  | 20c. LOCATION — City or Town, State<br><b>Brentwood, Maryland</b>                |   |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>B. Rauoch</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Rausch Funeral Home P.A.<br/>4405 Brookes Island Rd. Port Republic Maryland 20676</b>  |  |  |   |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Uremia</b><br><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><br>a. <b>Acute Renal Failure</b><br>b. <b>Acute Tubular Necrosis</b><br>c. _____<br>d. _____<br><br>Approximate Interval Between Onset and Death<br><b>7 days</b><br><b>3 wks</b> |  |  |  |   |  |  |   |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypothyroidism</b><br><b>Alzheimers</b>   |  |  |  |   |  |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |  |   |  |  |   |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____ |  |   |  |  |   |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M _____  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |   | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
|  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  |  |   | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                          |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |   |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Susan H. Prouty, MD</b>  |  |  |  |   |  | 29c. LICENSE NUMBER<br><b>D25731</b>   |   | 29d. DATE SIGNED (Month, Day, Year)<br><b>February 8, 1996</b>  |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Susan H. Prouty, MD 120 Hospital Rd. Prince Frederick, Maryland 20678</b>  |  |  |  |   |  |  |   |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB - 9 1996</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Jackson-Randall</b>   |  |  |   |   |  |   |  |

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |   |  |  |   |   |
|--|--|--|---|--|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Grace e Conner   |  |  |   | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>01 25 96   |  | 3. TIME OF DEATH<br>1:30 A M  |   |
| 4. SOCIAL SECURITY NUMBER<br>212-03-3359   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br>85 YRS. | 7. DATE OF BIRTH (Month, Day, Year)<br>11/19/10  |  | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Frederick health Care center   |  |  |   | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Frederick   |  | 9c. COUNTY OF DEATH<br>Frederick  |   |
| RESIDENCE OF DECEDENT  |  |  |   |  |  |   |   |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Fredenick   |   | 10c. CITY, TOWN OR LOCATION<br>Brunswick   |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO       |   |
| 10e. STREET AND NUMBER<br>125 Central Avenue   |  |  |   | 10f. ZIP CODE<br>21716   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |   | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White  |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 11<br>College (1-4 or 5+) 11   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Bookkeeper                      |   | 16b. KIND OF BUSINESS/INDUSTRY<br>J.P. Kann Lumber Co.   |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>Turner McGill Conner  |  |  |   | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Daisy Laycock   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>Constance Eyles  |  |  |   | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>Frederick, Maryland 21701   |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Park Heights Cemetery 1/29 Brunswick, MD                      |   | 20c. DATE<br>1/29  |  | 20d. LOCATION — City or Town, State<br>Brunswick, MD  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Barbara A. Williams, Owner  |  |  |   | 22. NAME AND ADDRESS OF FACILITY<br>John T. Williams Funeral Home<br>100 Petersville Rd. Brunswick, MD   |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |   |  |  |   |   |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  | a. Endometrial Carcinoma   |   |  |  |   | Approximate interval Between Onset and Death<br>Mos-years |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  | b. DUE TO (OR AS A CONSEQUENCE OF):  |   |  |  |   |   |
|  |  | c. DUE TO (OR AS A CONSEQUENCE OF):  |   |  |  |   |   |
|  |  | d. DUE TO (OR AS A CONSEQUENCE OF):  |   |  |  |   |   |
|  |  |  |   |  |  |   |   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |   |  |  |   |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |   | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |   | 28b. TIME OF INJURY<br>M   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                      |   |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |   | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                              |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |  |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>W. Williams MD  |  |  |   | 29c. LICENSE NUMBER<br>D16675  |  | 29d. DATE SIGNED (Month, Day, Year)<br>1/26/96  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>WAYNE ALLGOWER BRUNSWICK MD 21766   |  |  |   |  |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br>JAN-3-1996  |  |  |   | 32. REGISTRAR'S SIGNATURE<br>[Signature]   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.


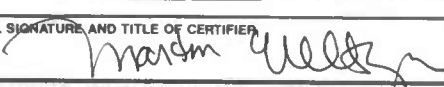
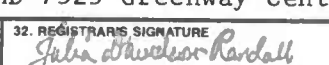
21740 ae

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 047113

|  |  |  |  |  |  |   |  |  |  |   |  |  |  |
|--|--|--|--|--|--|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>TINA MARIE CLIFTON</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>February 3, 1996</b>  |  |   |  | 3. TIME OF DEATH<br><b>10:00 A M</b>   |  |   |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>577-84-8149</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>35</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS.<br>HOURS MIN.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>October 12 1960</b>                                |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Florida</b> |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>6103 43rd STREET</b>  |  |  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>RIVERDALE</b>   |  |  |  | 9c. COUNTY OF DEATH<br><b>PRINCE GEORGE'S</b>   |  |  |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Prince George's</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Riverdale</b>  |  |   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |  |  |
| 10e. STREET AND NUMBER<br><b>6103 43rd Street</b>  |  |  |  |  |  | 10f. ZIP CODE<br><b>20737</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |  |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                         |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b></b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Cashier</b>  |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Food Service</b>                                |  |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Thomas H. Clifton</b>  |  |  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Ann E. Carrico</b>  |  |  |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Victoria Blades</b>   |  |  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6103 43rd St Riverdale, MD 20737</b>  |  |  |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory 2-5-96</b>  |  |   |  | 20c. LOCATION — City or Town, State<br><b>Alexandria, VA</b>                         |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><br><b>M00173</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>J.H. Eberwein Mortuary<br/>11855 Holly La #104 Waldorf, MD 20601</b>  |  |   |  |  |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>immune deficiency syndrome</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br><br>Approximate Interval Between Onset and Death<br><b>6 months</b> |  |  |  |  |  |   |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>   |  |  |  |  |  |   |  |  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide  |  |  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |  |  |
| 29a. CERTIFIER <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>(Check only one) 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |  |   |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><br><b>Martin D. Weltz</b>   |  |  |  |  |  | 29c. LICENSE NUMBER<br><b>D23743</b>  |  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>February 5, 1996</b>                                  |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Martin D. Weltz MD 7525 Greenway Center Dr #205 Greenbelt, MD 20770</b>  |  |  |  |  |  |   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 07 1996</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |   |  |  |  |   |  |  |  |





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 047114

|   |  |  |  |  |  |  |   |   |  |   |  |
|---|--|--|--|--|--|--|---|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Kenneth C. Cox</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JANUARY 31 96</b>   |  | 3. TIME OF DEATH<br><b>8:45 AM</b>   |   |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>145-07-4392</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>90</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>April 13 1905</b>                      |   | 8. BIRTHPLACE (State or Foreign Country)<br><b>New Jersey</b>                                   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Southern Maryland Hosp.</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Clinton</b>  |  |  | 9c. COUNTY OF DEATH<br><b>Prince Georges</b>                            |   |  |   |  |
| 10a. STATE<br><b>Maryland</b>   |  |  |  | 10b. COUNTY<br><b>Prince George's</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Clinton</b>                                    |   | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |   |  |
| 10e. STREET AND NUMBER<br><b>9106 Pineview Lane</b>   |  |  |  | 10f. ZIP CODE<br><b>20735</b>  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                             |   |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b> |   |  |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>5</b> College (1-4 or 5+) <b>College</b>  |  |  |  | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Plumber</b>   |  |  | 15b. KIND OF BUSINESS/INDUSTRY<br><b>Construction</b>                   |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Harvy A. Cox</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Unknown</b>  |  |  |   |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Owen Schwartz</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9106 Pineview Lane Clinton, MD 20735</b>   |  |  |   |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory 2-1-96</b>                      |  |  | 20c. LOCATION — City or Town, State<br><b>Alexandria, VA</b> |  |   |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>[Signature]</b> M00173  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>J.H. Eberwein Mortuary<br/>11855 Holly La Waldorf, MD #104 20601</b>  |  |  |   |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>GENERALIZED SEPSIS</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>METHICILLIN RESISTANT STAPHYLOCOCCUS AUREUS INFECTION 1WK</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br><b>CHRONIC LYMPHOCYTIC LEUKEMIA</b><br><b>CONGESTIVE HEART FAILURE</b><br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b><br><br>24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br><br>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |  |  |  |  |  |   |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |   | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>LUCIO S. VILLI-REAL M.D.</b>   |  |  |   | 29c. LICENSE NUMBER<br><b>D15513</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>1/31/96</b> |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>LUCIO S. VILLI-REAL, M.D. - 2 ST. PATRICK'S DRIVE, WALDORF MD 20603</b>   |  |  |  |  |  |  |   |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 07 1996</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |  |   |   |  |   |  |

31/12/00

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

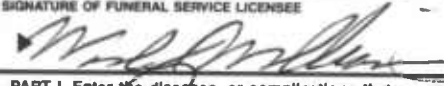
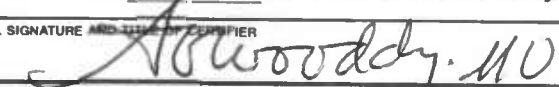
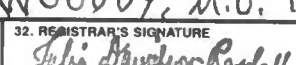
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 047115

|   |  |  |  |   |  |   |  |   |  |   |  |
|---|--|--|--|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Cecelia Bedrice Carpenter</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>Feb</b> DAY <b>3</b> YEAR <b>96</b>  |  | 3. TIME OF DEATH<br><b>1:05P</b>  |  |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>220-42-0329</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>92</b> YRS.  |  | 7. DATE OF BIRTH FEB. 26<br>(Month, Day, Year)<br><b>02-26-03</b>                           |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Waldorf Health Care</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Waldorf</b>   |  |   |  | 9c. COUNTY OF DEATH<br><b>Charles</b>   |  |   |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Charles</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>LaPlata</b>   |  |   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                 |  |   |  |
| 10e. STREET AND NUMBER<br><b>6425 Masons Springs Rd.</b>  |  |  |  | 10f. ZIP CODE<br><b>20646</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                  |  |   |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7</b><br>College (1-4 or 5+) <b>College</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Her Home</b>   |  |   |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Magruder Clements</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Sarah Jane Simmons</b>  |  |   |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Catherine L. Rison</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Same as #10</b>   |  |   |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Pisgah Meth. Church February 6, 1996 Pisgah, Maryland</b>  |  | DATE  |  | 20c. LOCATION — City or Town, State   |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><br><b>MO0668</b>  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Williams Funeral Home, P.A.<br/>Rt. 225 &amp; Glymont rd., Indian Head, Md. 20640</b>   |  |   |  |   |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Raynaud's Colic</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <b>Acute secondary to starvation</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <b>Cardiomegaly</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. <b>Anterior embolic Cardiovascular disease</b> |  |  |  |   |  |   |  | Approximate Interval Between Onset and Death<br><b>2 min</b><br><b>4 wks.</b><br><b>12 mos.</b><br><b>Years</b> |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Depression</b>   |  |  |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO           |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  |   |  |   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
|   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. SIGNATURE AND TIME OF CERTIFIER<br><br><b>WOODDY</b>   |  | 29c. LICENSE NUMBER<br><b>D11176 Md</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>02-06-96</b>                                      |  |   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>ARTHUR B. WOODDY, M.D. 100 Washington Ave LaPlata, Md. 20646</b>  |  |  |  |   |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 07 1996</b>   |  | 32. REGISTRAR'S SIGNATURE<br><br><b>Julia Drucker-Randall</b>   |  |   |  |   |  |   |  |   |  |

21540 25



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96

047116

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ALLEN THOMAS DICKERSON

2. Date of Death

Month Day Year  
FEBRUARY 6, 1996

3. Time of Death

5:00AM

4a. Facility Name (If not institution, give street and number)

426 STATE STREET

4b. City, Town, or Location of Death

SHARPTOWN

4c. County of Death

WICOMICO

Funeral  
Director

5. Social Security Number

213-24-0450

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

69

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
FEB. 11, 1926

9. Birthplace (State or Foreign Country)

DELAWARE

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

WICOMICO

10c. City, Town or Location

SHARPTOWN

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

426 STATE STREET

10f. Zip Code

21861

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

SALES

16b. Kind of Business/Industry

RETAIL

17. Father's Name (First, Middle, Last)

MINOS HENRY DICKERSON

18. Mother's Name (First, Middle, Maiden Surname)

CARRIE HASTINGS

19a. Informant's Name/Relationship (Type, Print)

RUTH G. DICKERSON, WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P. O. BOX 434, SHARPTOWN, MD 21861

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

SHARPTOWN FIREMENS CEM.

Date

2/10

20c. Location - City or Town, State

SHARPTOWN, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

ZELLER FUNERAL HOME, P.O. BOX 3171,  
1212 OLD OCEAN CITY ROAD, SALISBURY, MD 2180223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. *Acute Myocardial Infarction*

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

minutes

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. *Coronary Artery Disease*

Due to (or as a consequence of):

3-4 years

c. \_\_\_\_\_  
Due to (or as a consequence of):d. \_\_\_\_\_  
Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Chronic Renal Failure Secondary to**Chronic Glomerulonephritis*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?  
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D-20050

29d. Date signed (Month, Day, Year)

2/17/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BENITO S. CHAN 5417-D Riverdale Rd. Sully, MD 2189

31. Date filed (Month, Day, Year)

FEB 09 1996

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04717

|   |  |   |  |   |  |   |   |  |  |  |
|---|--|---|--|---|--|---|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>GLADYS FLORENCE DENGLER</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>02</b> DAY <b>11</b> YEAR <b>96</b>  |  | 3. TIME OF DEATH<br><b>7:10 A M</b>   |   |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>218-40-6703</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 8. AGE (In yrs. last birthday)<br><b>86</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Aug. 3, 1909</b>                                  |   | 8. BIRTHPLACE (State or Foreign Country)<br><b>Frederick County Md</b> |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Bel Forest Nursing &amp; Rehab Ctr</b>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Forest Hill</b>   |  |   | 9c. COUNTY OF DEATH<br><b>Harford</b>   |  |  |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Baltimore</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Perry Hall</b>  |  |   | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO       |  |  |  |
| 10e. STREET AND NUMBER<br><b>4113 Perry View Road</b>   |  |   |  | 10f. ZIP CODE<br><b>21236</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |  |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  |   | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                            |  |  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b>  |  | 15b. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Bar Owner</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Self-Employed</b>  |  |   |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Martin L. Weddle</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Martha E. Shuff</b>   |  |   |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mrs. Dorothy Downs</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4113 Perry View Road Baltimore, Md. 21236</b>   |  |   |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Moreland Park Cem. Feb. 14, 1996</b>  |  | DATE<br><b>Feb. 14, 1996</b>  |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, Maryland</b>                           |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>E. F. Lassahn</b>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>E. F. Lassahn Funeral Home<br/>11750 Belair Road Kingsville, Md. 21087</b>   |  |   |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Gastrointestinal bleed</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>a. <b>Gastrointestinal bleed</b><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |   |  |   |  |   | Approximate Interval Between Onset and Death<br><b>none</b>   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Alzheimer's</b>  |  |   |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |   |  |   |  |   |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |   |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   | 28d. DESCRIBE NOW INJURY OCCURRED                                      |  |  |
|   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>John J. [Signature]</b><br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |   |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>John J. [Signature]</b>   |  |   |  | 29c. LICENSE NUMBER<br><b>D28 339</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>February 11 1996</b>                              |   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>John J. [Signature] 101 E. Wheel Blvd Bel Air MD 21033</b>  |  |   |  |   |  |   |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 21 1996</b>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><b>John J. [Signature]</b>   |  |   |   |  |  |  |

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04718

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Arthur Gordon DUNNING

2. Date of Death

Month

Day

Year

Feb.

4

1996

3. Time of Death

1:40 A

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

Funeral  
Director

5. Social Security Number

037-20-5873

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

77

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Feb. 8 1918

9. Birthplace (State or Foreign Country)

Massachusetts

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11907 Robinwood Drive

10f. Zip Code

21742

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: 1966

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

0-12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Self-employed

16b. Kind of Business/Industry

Security

17. Father's Name (First, Middle, Last)

Arthur Dunning

18. Mother's Name (First, Middle, Maiden Surname)

Louise (unknown)

19a. Informant's Name/Relationship (Type, Print)

June E. Dunning

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11907 Robinwood Drive Hagerstown, Md. 21742

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Hagerstown Crematory 2-6-96

Date

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

Scott Minnich

22. Name and Address of Facility Minnich Funeral Home

415 E. Wilson Blvd. Hagerstown, Md. 21740

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Cardiac pulmonary arrest

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

30 Minute

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. pulmonary fibrosis

Due to (or as a consequence of):

unknown

c. Congestive heart failure

Due to (or as a consequence of):

unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Shahen Iqbal

29c. License number

D47288

29d. Date signed (Month, Day, Year)

2/5/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shahen Iqbal m.o. 12821 Oak Hill Ave. Hag. md 21742

Filed (Month, Day, Year)

FEB 7 1996

31. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. DECEASED'S NAME (First, Middle, Last)  |  |  |  | 2. DATE OF DEATH  |  |  |  | 3. TIME OF DEATH   |  |
|---|--|--|--|---|--|--|--|--|--|
| Mary Edith DICK   |  |  |  | January 30, 1996  |  |  |  | 2245 M   |  |
| 4. SOCIAL SECURITY NUMBER   |  | 5. SEX   |  | 6. AGE (In yrs. last birthday)  |  | 7. DATE OF BIRTH   |  | 8. BIRTHPLACE (State or Foreign Country)                                     |  |
| 220- 58- 2945   |  | 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                 |  | 80 YRS.   |  | Dec. 3, 1915   |  | Maryland   |  |
| 9a. FACILITY NAME (If not institution, give street and number)  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH   |  |  |  | 9c. COUNTY OF DEATH  |  |
| Washington County Hospital  |  |  |  | Hagerstown  |  |  |  | Washington   |  |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |  |  |  |  |
| 10a. STATE  |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION   |  |  |  | 10d. INSIDE CITY LIMITS?   |  |
| Maryland  |  | Washington   |  | Boonsboro   |  |  |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO      |  |
| 10e. STREET AND NUMBER  |  |  |  | 10f. ZIP CODE   |  | 10g. CITIZEN OF WHAT COUNTRY?                                |  |  |  |
| 19852 Toms Rd.  |  |  |  | 21713   |  | U.S.A  |  |  |  |
| 11. MARITAL STATUS  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)  |  |  |  | 14. RACE — American Indian, Black, White, etc. Specify:                      |  |
| 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  |  |  | Specify: White   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |
| Elementary/Secondary (0-12) 8 College (14 or 15+) 5   |  |  |  | Homemaker   |  |  |  | Own Home   |  |
| 17. FATHER'S NAME (First, Middle, Last)   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)   |  |  |  |  |  |
| Samuel L. McLucas   |  |  |  | Amy V. Moser  |  |  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)   |  |  |  |  |  |
| Kenneth L. Dick   |  |  |  | 19852 Toms Rd. Boonsboro, Maryland 21713  |  |  |  |  |  |
| 20a. METHOD OF DISPOSITION  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)                      |  | DATE  |  | 20c. LOCATION — City or Town, State                          |  |  |  |
| 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | Park Head Cemetery   |  |   |  | Hancock, Md. 21750   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE   |  |  |  | 22. NAME AND ADDRESS OF FACILITY  |  |  |  |  |  |
| John H. BAST, Jr.   |  |  |  | 7606 Old National Pike<br>BAST FUNERAL HOME, Boonsboro, Md. 21713   |  |  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |  |  |   |  |  |  | Approximate Interval Between Onset and Death                                 |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiorespiratory arrest  |  |  |  |   |  |  |  | 15 min   |  |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  |  |  |   |  |  |  | 9 days   |  |
| a. acute peritonitis  |  |  |  |   |  |  |  | 2 days   |  |
| b. hypotension  |  |  |  |   |  |  |  | 5 days   |  |
| c. Ischemic Bowel   |  |  |  |   |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?   |  |
| End Stage renal disease<br>Congestive heart failure   |  |  |  |   |  |  |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO      |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |  |   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  |  |
|   |  |  |  |   |  |  |  | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                 |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?  |  |  |  | 26. PLACE OF DEATH (Check only one)   |  |  |  |  |  |
| 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
| 27. MANNER OF DEATH   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY   |  | 28c. INJURY AT WORK?   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |
| 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide  |  |  |  |   |  | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |  |  |
| 29a. CERTIFIER (Check only one)   |  |  |  | 29b. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 29c. LOCATION (Street and Number or Rural Route Number, City or Town, State) |  |
| 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER   |  |  |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)                          |  |  |  |
| Bruno Pulisanti, MD   |  |  |  | D20233  |  | 1/31/96  |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)   |  |  |  |   |  |  |  |  |  |
| Dr. Bapurao 12931 Oak Hill Avenue Hagerstown Md.  |  |  |  |   |  |  |  |  |  |
| 31. DATE (Month, Day, Year)   |  |  |  | 32. REGISTRAR'S SIGNATURE   |  |  |  |  |  |
| FEB 1 1996  |  |  |  | [Signature]   |  |  |  |  |  |

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04721

|  |   |   |   |  |  |  |  |  |
|--|---|---|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Thelma May Desautels</b>   |   |   |  | 2. Date of Death<br>Month Day Year<br><b>February 7, 1996</b>  |  | 3. Time of Death<br><b>18:41</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>CALVERT MEMORIAL HOSPITAL</b>  |   |   |  | 4b. City, Town, or Location of Death<br><b>PRINCE FREDERICK</b>  |  | 4c. County of Death<br><b>CALVERT</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>026-26-0962</b>   |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>61</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>10-26-1934</b>   |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>MASS.</b>  |   | 10a. State<br><b>MARYLAND</b>   |  | 10b. County<br><b>CALVERT</b>  |  | 10c. City, Town or Location<br><b>LUSBY</b>  |  |
| To Be Completed by Funeral Director  | 10e. Street and Number<br><b>338 LONGHORN CIRCLE</b>  |   | 10f. Zip Code<br><b>20657</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>CLERICAL WORKER</b>  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>U.S. GOVT.</b>                        |  | 16b. Kind of Business/Industry<br><b>U.S. GOVT.</b>  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>WILLIAM B. MONIZ</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MARY T. SOUZA</b>  |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>DIANNE HOUSEKNECHT (DAUGHTER)</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>SAME AS #10</b>  |  |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MD. VETERANS CEMETERY</b>  |  | 20c. Location - City or Town, State<br><b>2-12-96 CHELTENHAM, MARYLAND</b>   |  | 20d. Date  |  |
|  | 21. Signature of Funeral Service Licensee<br>   |   | 22. Name and Address of Facility<br><b>RAYMOND FUNERAL HOME<br/>DUNKIRK, MARYLAND 20754</b>   |  |  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death) <b>INTRACRANIAL HEMMORRHAGE</b><br>Approximate Interval Between Onset and Death <b>3 DAYS</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><br>a. _____ Due to (or as a consequence of):<br>b. _____ Due to (or as a consequence of):<br>c. _____ Due to (or as a consequence of):<br>d. _____ |   |   |  |  |  |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
|  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>                      |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28d. Describe how injury occurred   |   |  |  |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   | 28e. Describe how injury occurred   |   |  |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   |   |  |  |  |  |  |
| 29b. Signature and title of certifier<br>   |   | 29c. License number<br><b>047810</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>2/8/96</b> |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DAVID J. TREDIO M.D. Prince Frederick, Md. 20678</b>  |   |   |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB - 9 1996</b>   |   | 32. Registrar's Signature<br>  |   |  |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

ISSN 0013-788X

Journal of the American Chemical Society  
Volume 78, Number 1, January 1956  
Published by the American Chemical Society

Subscription prices: \$12.00 per volume (12 issues) in advance.  
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 96 04722

|  |  |   |   |  |  |  |  |  |
|--|--|---|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Florinda G. De Pronzato  |   |   |  | 2. Date of Death<br>Month Day Year<br>February 6 1996  |  | 3. Time of Death<br>AM   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>1702 Lake Avenue   |   |   |  | 4b. City, Town, or Location of Death<br>Shady Side   |  | 4c. County of Death<br>Anne Arundel                              |  |
| Funeral<br>Director  | 5. Social Security Number<br>215-44-3571   |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>85 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>Oct 29 1910               |  |
|  | 9. Birthplace (State or Foreign Country)<br>Argentina  |   | 10a. State<br>MD  |  | 10b. County<br>Anne Arundel  |  | 10c. City, Town or Location<br>Shady Side                        |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 10e. Street and Number<br>1702 Lake Avenue  |  | 10f. Zip Code<br>20764   |  | 10g. Citizen of What Country?<br>United States                   |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Navar Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 4 College (1-4 or 5+)   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Teacher                                  |  | 16b. Kind of Business/Industry<br>Education/Private Schools  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>Manuel Gonzales   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Rosalea Crespo  |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>Carlos A. Pronzato   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1702 Lake Avenue Shady Side, Maryland 20764   |  |  |  |
|  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Ft. Lincoln Crematory   |  | 20c. Location - City or Town, State<br>Brentwood, Maryland   |  | 20d. Date<br>2/7/96  |  |
|  | 21. Signature of Funeral Service Licensee<br><i>Donald L. Lupton</i>   |   |   |  | 22. Name and Address of Facility<br>John M. Taylor Funeral Home, Inc.<br>147 Duke of Gloucester St. Annapolis, MD 21401  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <i>cardiovascular arrest</i><br>Due to (or as a consequence of):<br>b. <i>CVA</i><br>Due to (or as a consequence of):<br>c. <i>Asthma</i><br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><br>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Pneumonia</i> |   |   |  |  |  |  |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |   |   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  |
|  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |   |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |  |  |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |
| 28d. Describe how Injury occurred  |  |   |   | 28e. Place of Injury - At home, farm, street, tectory, office building, etc. (Specify) |  |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |   |  |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician<br>2 <input checked="" type="checkbox"/> Medical Examiner   |  | To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                          |   |  |  |  |  |  |
| 29b. Signature and title of certifier<br><i>Jack R. Lichtenstein</i>   |  | 29c. License number<br>D08194   |   | 29d. Date signed (Month, Day, Year)<br>February 7, 1996                                |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>Jack R. Lichtenstein, M.D. 7845 Oakwood Road Glen Burnie, MD 21061   |  |   |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>FEB 08 1996   |  | 32. Registrar's Signature<br><i>John A. ...</i>   |   |  |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State  
Registrar

SECRET

1. The purpose of this document is to provide information regarding the activities of the [redacted] in the [redacted] area.

2. The [redacted] has been observed in the [redacted] area, and it is believed that it is engaged in [redacted] activities.

3. It is recommended that the [redacted] be monitored closely, and any further activities be reported to the appropriate authorities.

4. The [redacted] is believed to be a [redacted] organization, and it is believed that it is engaged in [redacted] activities.

5. It is recommended that the [redacted] be monitored closely, and any further activities be reported to the appropriate authorities.

6. The [redacted] is believed to be a [redacted] organization, and it is believed that it is engaged in [redacted] activities.

7. It is recommended that the [redacted] be monitored closely, and any further activities be reported to the appropriate authorities.

8. The [redacted] is believed to be a [redacted] organization, and it is believed that it is engaged in [redacted] activities.

9. It is recommended that the [redacted] be monitored closely, and any further activities be reported to the appropriate authorities.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04723

|  |  |   |  |   |  |   |   |   |  |
|--|--|---|--|---|--|---|---|---|--|
| 1. DECEASED'S NAME (First, Middle, Last)<br>Mary Loleta Denny  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>January 24, 1996  |  | 3. TIME OF DEATH<br>2:10 P M  |   |   |  |
| 4. SOCIAL SECURITY NUMBER<br>213-01-5681   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>80 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>January 5, 1916   |   | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland                |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Anne Arundel Medical Center  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Annapolis  |  |   | 9c. COUNTY OF DEATH<br>Anne Arundel   |   |  |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Queen Anne's   |  | 10c. CITY, TOWN OR LOCATION<br>Chester  |  |   | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |   |  |
| 10e. STREET AND NUMBER<br>1107 Little Creek Road   |  |   |  | 10f. ZIP CODE<br>21619  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |   | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                                 |   |  |
| 15. DECEASED'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>7   |  | 16a. DECEASED'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Food services                      |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Queen Anne's County Board of Education  |  |   |   |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Samuel Comegeys   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Mina Rhodes  |  |   |   |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>(Son)<br>Benjamin Rodger Denny, Jr.  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>212 Grove Cove Rd., Centreville, Md. 21617   |  |   |   |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Stevensville Cemetery  |  | DATE<br>Jan. 27, 1996   |  | 20c. LOCATION — City or Town, State<br>Stevensville, Md.  |   |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Chad M. Helfenbein  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>Tom Helfenbein Funeral Homes, P.A.<br>106 Shamrock Rd., Chester, Md. 21619  |  |   |   |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. Congestive Heart Failure<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. Ischemic Cardiomyopathy<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>Urinary Tract Infection<br>Type 2 Diabetes mellitus<br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> |  |   |  |   |  |   |   | Approximate Interval Between Onset and Death<br>4 days<br>3-5 years |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |   |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |   |  |   |  |   |   |   |  |
| 26. PLACE OF DEATH (Check only one)<br>1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |   |  |   |  |   |   |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |   | 28d. DESCRIBE HOW INJURY OCCURRED                                   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |   |   |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>John P. Serlemitsos MD  |  |   |  | 29c. LICENSE NUMBER<br>D32654   |  | 29d. DATE SIGNED (Month, Day, Year)<br>January 24, 1996   |   |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>John P. Serlemitsos 1509 Ritchie Hwy, Arnold, MD 21012  |  |   |  |   |  |   |   |   |  |
| 31. DATE FILED (Month, Day, Year)<br>01/26/96  |  |   |  | 32. REGISTRAR'S SIGNATURE<br>John Serlemitsos   |  |   |   |   |  |

20 2575



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR   |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 96 04724  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|---|--|---|--|--|--|
| CERTIFICATE OF DEATH  |  |  |  | REG. NO.  |  |  |  |   |  |   |  |  |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br>HARRY ANTHONY DAVIS   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>02 02 1996  |  |  |  | 3. TIME OF DEATH<br>12:52 p m   |  |   |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br>302-14-7621  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>73 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>01/15/23   |  | 8. BIRTHPLACE (State or Foreign Country)<br>OHIO |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>GARRETT MEMORIAL HOSPITAL   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>OAKLAND  |  |  |  | 9c. COUNTY OF DEATH<br>GARRETT  |  |   |  |  |  |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |  |  |   |  |   |  |  |  |
| 10a. STATE<br>WV  |  | 10b. COUNTY<br>PRESTON   |  | 10c. CITY, TOWN OR LOCATION<br>TERRA ALTA   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO       |  |   |  |  |  |
| 10e. STREET AND NUMBER<br>AURORA PIKE   |  |  |  | 10f. ZIP CODE<br>26764  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  |   |  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>WHITE                                       |  |   |  |  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 03 College (1-4 or 5+) 03  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>FARMER  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>AGRICULTURE   |  |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>RICHARD DAVIS  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>BESSIE EWING   |  |  |  |   |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>ALAN MULLINS  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>PO BOX 99, AURORA, WV., 26705  |  |  |  |   |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>OMEGA CREMATORY   |  | DATE<br>2/6/96  |  | 20c. LOCATION — City or Town, State<br>MORGANTOWN, WV.                               |  |   |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Arthur H. Wright   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>105 HIGHLAND AVE.<br>TERRA ALTA, WV, 26764  |  |  |  |   |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. Ventricular Fibrillation, Acute<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. Arteriosclerotic Cardio-Vascular Disease<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |  |  | Approximate Interval Between Onset and Death<br>Sudden<br>Unknown   |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Renal failure - recent hospitalization  |  |  |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |  |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |  |   |  |  |  |   |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |   |  |   |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Herbert H. Leighton, M.D.  |  |  |  | 29c. LICENSE NUMBER<br>D 05658  |  | 29d. DATE SIGNED (Month, Day, Year)<br>February 2, 1996   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Herbert H. Leighton, M.D., 502 E Oak Street, Oakland, Maryland 21550   |  |  |  |   |  |  |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>FEB - 5 1996   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>John Andrew Ruff   |  |  |  |   |  |   |  |  |  |

15-1050

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |   |   |                                 |  |   |  |                                   | 96 04725<br>REG. NO.  |
|--|--|---|---|---|---------------------------------|--|---|--|-----------------------------------|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>PAUL REVERE DONOWAY</b>   |  |   |   |   |                                 | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Feb. 3, 1996</b>  |   | 3. TIME OF DEATH<br><b>12:51A. M</b>                         |                                   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>220-28-0312</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 6. AGE (in yrs. last birthday)<br><b>64</b> YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS  |                                 | IF UNDER 24 HRS.<br>HOURS MIN.   |   | 7. DATE OF BIRTH (Month, Day, Year)<br><b>April 21, 1931</b> |                                   | 8. BIRTHPLACE (State or Foreign Country)<br><b>Md.</b>  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>6601 Worchester Highway</b>   |  |   |   |   |                                 | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Newark</b>   |   | 9c. COUNTY OF DEATH<br><b>Worchester</b>                     |                                   |   |
| 10a. STATE<br><b>Md.</b>   |  |   |   |   |                                 | 10b. COUNTY<br><b>Worchester</b>   |   | 10c. CITY, TOWN OR LOCATION<br><b>Newark</b>                 |                                   | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |
| 10e. STREET AND NUMBER<br><b>6601 Worchester Highway</b>   |  |   |   |   |                                 | 10f. ZIP CODE<br><b>21841</b>  |   | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>               |                                   |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>1959</b> |   | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |                                 |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>white</b>                  |  |                                   |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>College</b>  |  |   | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Brick Mason</b>  |   |                                 | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Own Business</b>  |   |  |                                   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>P. Walter Donoway</b>  |  |   |   |   |                                 | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Florence Jackson Donoway</b>   |   |  |                                   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Maude C. Donoway</b>  |  |   |   |   |                                 | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6601 Worchester Highway, Newark, Md. 21841</b> |   |  |                                   |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Trinity Gar. Memories 2/6</b>   |   |                                 | 20c. LOCATION — City or Town, State<br><b>Newark, Md.</b>  |   |  |                                   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Patricia L. Dennis</i>   |  |   |   |   |                                 | 22. NAME AND ADDRESS OF FACILITY<br><b>Dennie Funeral Home<br/>P.O. Box, 87, Snow Hill, Md. 21863</b>  |   |  |                                   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |   |   |                                 |  |   |  |                                   | Approximate Interval Between Onset and Death  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>1. NUTRITIONAL FAILURE</b>  |  |   |   |   |                                 |  |   |  |                                   | <b>37MOS</b>  |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  |  |   |   |   |                                 |  |   |  |                                   |   |
| 2. <b>Small CELL LUNG CANCER</b>   |  |   |   |   |                                 |  |   |  |                                   | <b>17K</b>  |
| 3. _____   |  |   |   |   |                                 |  |   |  |                                   |   |
| 4. _____   |  |   |   |   |                                 |  |   |  |                                   |   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DIABETES HYPERTENSION DEPRESSION</b>  |  |   |   |   |                                 |  |   |  |                                   |   |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |   |   |                                 |  |   |  |                                   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>  |  |   |   |   |                                 |  |   |  |                                   |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |                                 |  |   |  |                                   |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  |   | 28a. DATE OF INJURY (Month, Day, Year)  |   | 28b. TIME OF INJURY<br><b>M</b> |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED |   |
|  |  |   | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |   |                                 |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                |  |                                   |   |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |   |                                 |  |   |  |                                   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Robert C. La Mar, MD</i>   |  |   |   |   |                                 | 29c. LICENSE NUMBER<br><b>D-5865</b>   |   | 29d. DATE SIGNED (Month, Day, Year)<br><b>FEB 6, 1996</b>    |                                   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>ROBERT C. LA MAR, MD. 104 N. BAY ST. SNOW HILL, MD 21843</b>   |  |   |   |   |                                 |  |   |  |                                   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 05 1996</b>  |  |   | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>   |   |                                 |  |   |  |                                   |   |





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04726

|  |  |  |  |   |   |   |                                |  |   |                                   |  |   |  |   |  |
|--|--|--|--|---|---|---|--------------------------------|--|---|-----------------------------------|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Savilla Gail EMBLY   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>February 2, 1996  |   |   |                                | 3. TIME OF DEATH<br>9:30 p.m.  |   |                                   |  |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br>220-28-3024   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday)<br>72 YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS                    |   | IF UNDER 24 HRS.<br>HOURS MIN. |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>Sept. 18, 1923  |                                   | 8. BIRTHPLACE (State or Foreign Country)<br>Pennsylvania |   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>862 View Street  |  |  |  |   | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Hagerstown |   |                                |  |   | 9c. COUNTY OF DEATH<br>Washington |  |   |  |   |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |   |   |                                |  |   |                                   |  |   |  |   |  |
| 10a. STATE<br>Maryland   |  |  | 10b. COUNTY<br>Washington  |   |   | 10c. CITY, TOWN OR LOCATION<br>Hagerstown   |                                |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |                                   |  |   |  |   |  |
| 10e. STREET AND NUMBER<br>862 View Street  |  |  |  |   |   | 10f. ZIP CODE<br>21742  |                                |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |                                   |  |   |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |   |   | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yea or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |                                |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: white                                  |                                   |  |   |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 0-8 College (1-4 or 5+) 0  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>homemaker  |   |   |                                | 16b. KIND OF BUSINESS/INDUSTRY<br>her home   |   |                                   |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>William Henry Truett  |  |  |  |   |   | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Mary Catherine Eley  |                                |  |   |                                   |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Mary K. Embly  |  |  |  |   |   | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3445 Dillward Drive, Columbus, Ohio  |                                |  |   |                                   |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Rest Haven Cemetery 2-696  |   |   |                                | 20c. LOCATION — City or Town, State<br>Hagerstown, Maryland                          |   |                                   |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Scott Minnich   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Minnich Funeral Home<br>415 East Wilson Blvd., Hagerstown, MD 21740   |   |   |                                |  |   |                                   |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. <i>Cardio pulmonary arrest</i><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. <i>Lung Cancer</i><br>c. <i>Chronic Obstructive pulmonary disease</i><br>d. <i></i> |  |  |  |   |   |   |                                |  |   |                                   |  | Approximate Interval Between Onset and Death<br>30 Weeks<br>Unknown<br>Unknown                            |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |  |   |   |   |                                |  |   |                                   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |                                |  |   |                                   |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide   |  |  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)   |   | 28b. TIME OF INJURY<br>M  |                                | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   | 28d. DESCRIBE HOW INJURY OCCURED  |  |   |  |   |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  |   |   | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |                                |  |   |                                   |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |   |   |                                |  |   |                                   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Sheher 2/5/96   |  |  |  |   |   | 29c. LICENSE NUMBER<br>D47288   |                                |  | 29d. DATE SIGNED (Month, Day, Year)<br>2/5/96   |                                   |  |   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Shahen Iqbal md 12821 Oak Hill Avenue, Hagerstown, MD 21742   |  |  |  |   |   |   |                                |  |   |                                   |  |   |  |   |  |
| 31. FILED (Month, Day, Year)<br>FEB 6 1996   |  |  |  | 32. REGISTRAR'S SIGNATURE   |   |   |                                |  |   |                                   |  |   |  |   |  |

2872 5

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR  |  |   |   | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 96 04727   |  |   |  |   |  |
|--|--|---|---|---|--|---|--|--|--|---|--|---|--|
| CERTIFICATE OF DEATH   |  |   |   | REG. NO.  |  |   |  |  |  |   |  |   |  |
| 1. DECEASED'S NAME (First, Middle, Last)<br>Rosbia Charles ELLIOTT   |  |   |   | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>JANUARY 29 1996   |  |   |  | 3. TIME OF DEATH<br>1225 P M   |  |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br>234-27-6408   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  | 6. AGE (In yrs. last birthday)<br>80 YRS. | 7. DATE OF BIRTH (Month, Day, Year)<br>Aug. 13, 1915  |  | 8. BIRTHPLACE (State or Foreign Country)<br>Virginia  |  |  |  |   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Washington County Hospital   |  |   |   | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Hagerstown   |  |   |  | 9c. COUNTY OF DEATH<br>Washington  |  |   |  |   |  |
| RESIDENCE OF DECEASED  |  |   |   |   |  |   |  |  |  |   |  |   |  |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Washington   |   | 10c. CITY, TOWN OR LOCATION<br>Hagerstown   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |  |  |   |  |   |  |
| 10e. STREET AND NUMBER<br>11311 Dogwood Drive  |  |   |   | 10f. ZIP CODE<br>21740  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  |  |  |   |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |   | 13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>white                                 |  |  |  |   |  |   |  |
| 15. DECEASED'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 5<br>College (1-4 or 5+) 0  |  | 16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>custodian   |   | 16b. KIND OF BUSINESS/INDUSTRY<br>hospital  |  |   |  |  |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Charles Ogden Elliott   |  |   |   | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Valley Christine Kees  |  |   |  |  |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Ishmael Elliott  |  |   |   | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>14717 Daley Road, Hagerstown, Maryland 21740   |  |   |  |  |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Mt. Zion Cemetery 2-1-96   |   | 20c. LOCATION — City or Town, State<br>Boonsboro, Maryland  |  |   |  |  |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |   |   | 22. NAME AND ADDRESS OF FACILITY<br>MINNICH FUNERAL HOME<br>415 E. Wilson Blvd., Hagerstown, Md. 21740  |  |   |  |  |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → CONGESTIVE HEART FAILURE<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF): CEREBRAL VASCULAR DISEASE<br>b. DUE TO (OR AS A CONSEQUENCE OF): DEMENTIA<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Approximate Interval Between Onset and Death<br>3-5 yrs |  |   |   |   |  |   |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |   |   |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                    |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |  |   |  |  |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)  |   | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  |   |  |
|  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |   |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                        |  |  |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |   |   |  |   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br> |  | 29c. LICENSE NUMBER<br>1122043  |  | 29d. DATE SIGNED (Month, Day, Year)<br>2/1/96 |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>1795 HILWELL RD HAGERSTOWN MD 21740   |  |   |   |   |  |   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>FEB 1 1996  |  |   |   | 32. REGISTRAR'S SIGNATURE<br>  |  |   |  |  |  |   |  |   |  |

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1 - FOR STATE REGISTRAR  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | CERTIFICATE OF DEATH  |  | REG. NO.   |  |  |  |
|--|--|--|--|---|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Viola M Earp</b>  |  |  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>1</b> DAY <b>31</b> YEAR <b>96</b>   |  | 3. TIME OF DEATH<br><b>6:20 PM</b>   |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>218-54-8008</b>  |  | 5. SEX<br><b>1</b> <input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 6. AGE (In yrs. last birthday)<br><b>96</b> YRS. | 7. DATE OF BIRTH (Month, Day, Year)<br><b>1-30-00</b>   | 8. BIRTHPLACE (State or Foreign Country)<br><b>MD.</b> |   |  |  |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Maroon Manor Nsg Home</b>   |  |  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Princess Anne, MD</b>   |  | 9c. COUNTY OF DEATH<br><b>Somerset</b>   |  |  |  |
| 10a. STATE<br><b>MD.</b>   |  | 10b. COUNTY<br><b>SOMERSET</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>PRINCESS ANNE</b>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                         |  |  |  |  |  |
| 10e. STREET AND NUMBER<br><b>11974 Edgemoor Terrace</b>  |  |  |  | 10f. ZIP CODE<br><b>21853</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>US</b>  |  |  |  |  |  |
| 11. MARITAL STATUS<br><b>3</b> <input checked="" type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  |  |  |  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>8 YRS</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>HARRY E. MULLIGAN</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>CORA HOWARD</b>   |  |   |  |  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>STANLEY EARP</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>20518 NANTICOKE DR. NANTICOKE, MD 21840</b>   |  |   |  |  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State<br><b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>PARK LAWN CEMETERY 2/6</b>   |  | 20c. LOCATION — City or Town, State<br><b>Rockville, MD</b>   |  |   |  |  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>C. J. Fennell</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>MESSICK Funeral Home<br/>PO Box 61<br/>VIRGATIE, MD 21814</b>  |  |   |  |  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Arteriosclerotic Heart Disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>Generalized Atherosclerosis</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>DUE TO (OR AS A CONSEQUENCE OF):<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>Cerebrovascular Accident</b><br><b>Diabetes Mellitus Type II</b><br><b>Hypothyroidism</b> |  |  |  |   |  |   |  |  |  | Approximate Interval Between Onset and Death<br><b>5 yrs</b><br><b>8 yrs</b> |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Cerebrovascular Accident</b><br><b>Diabetes Mellitus Type II</b><br><b>Hypothyroidism</b>   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA<br>OTHER: <b>4</b> <input checked="" type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify) |  |   |  |   |  |  |  |  |  |
| 27. MANNER OF DEATH<br><b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending investigation<br><b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined<br><b>3</b> <input type="checkbox"/> Suicide <b>7</b> <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO           |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  |
| 29a. CERTIFIER (Check only one)<br><b>1</b> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Gregorio M. Bellosso M.D.</b>  |  | 29c. LICENSE NUMBER<br><b>D 29505</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>1-31-96</b>   |  |  |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>GREGORIO M. BELLOSO, M.D. 4421 BEECHWOOD PL, CRISFIELD, MD 21817</b>   |  |  |  |   |  |   |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 05 1996</b>  |  | 32. REGISTRAR'S SIGNATURE<br><b>John Davidson Randall</b>  |  |   |  |   |  |  |  |  |  |

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04729

|  |  |  |  |   |  |  |   |
|--|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>JENNIE GRACE ELSE ROAD</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>02</b> - DAY <b>03</b> - YEAR <b>1996</b>  |  | 3. TIME OF DEATH<br><b>4:45 A M</b>  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>212-40-6881</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>85</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>12/17/10</b>   |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Carroll County Hospital</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Westminster</b>  |   |
| 9c. COUNTY OF DEATH<br><b>Carroll</b>  |  |  |  | 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Carroll</b>  |   |
| 10c. CITY, TOWN OR LOCATION<br><b>Hampstead</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>3805 Sunnyfield Court Unit I.A.</b>   |   |
| 10f. ZIP CODE<br><b>21074</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |   |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>College</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Own Home</b>  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Samuel Elseroad</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Ida Sedonia Raver</b>   |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Samuel Glenn Elseroad</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5423 Mt. Gilead Road, Reisterstown, MD 21136</b>  |  |  |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Mt. Gilead Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Reisterstown, MD</b>   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Steven W. Eline</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Eline Funeral Home<br/>934 S. Main St, Hampstead, MD 21074</b>   |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Intracranial Bleed</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>Hypertension</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>Hypercholesterolemia</b><br>DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  |  | Approximate Interval Between Onset and Death<br><b>4 hrs</b><br><b>years</b><br><b>years</b>          |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  |   |  |  |   |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>  |  |  |  |   |  |  |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |   |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28b. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Lamprey-Mills INTERNIST</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D44462</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>02/03/96</b>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>NIL LAMPREY-MILLS, CARROLL COUNTY GENERAL HOSPITAL</b>   |  |  |  |   |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br><b>02/03/96</b>   |  | 32. REGISTRAR'S SIGNATURE<br><b>FEB - 7 1996 John Shuck-Russell</b>  |  |   |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

25518 27



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04730

|   |  |  |   |   |  |  |  |  |
|---|--|--|---|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>John Ellsworth Eyler   |  |   |   | 2. Date of Death<br>Month Day Year<br>January 28, 1996   |  | 3. Time of Death<br>5:16 pm  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Frederick Memorial Hospital  |  |   |   | 4b. City, Town, or Location of Death<br>Frederick  |  | 4c. County of Death<br>Frederick   |  |
| Funeral<br>Director   | 5. Social Security Number<br>220-18-0275   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>70 Yrs.   | 8. Date of Birth (Month, Day, Year)<br>Feb. 4, 1925 | 9. Birthplace (State or Foreign Country)<br>Maryland   |  |  |  |
|   | Usual Residence of Decedent  |  |   |   |  |  |  |  |
| To Be Completed by Funeral Director   | 10a. State<br>Maryland   | 10b. County<br>Frederick   | 10c. City, Town or Location<br>Rocky Ridge  |   |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |
|   | 10e. Street and Number<br>9811 A Longs Mill Road   |  |   | 10f. Zip Code<br>21778                              |  | 10g. Citizen of What Country?<br>U.S.A.  |  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 9 College (1-4or 5+) 9  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Truck Driver                             |   | 16b. Kind of Business/Industry<br>Stone Company  |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>Raymond Ellsworth Eyler   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Nettie Elizabeth Boozer   |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Barbara L. Eyler   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>9811 A Longs Mill Road, Rocky Ridge, MD 21778   |  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Mt. Tabor Cemetery  |   | Date<br>1/31   |  | 20c. Location - City or Town, State<br>Rocky Ridge, Maryland   |  |
|   | 21. Signature of Funeral Service Licensee<br>  |  |   |   | 22. Name and Address of Facility<br>ROBERT E. DAILEY & SON FUNERAL HOMES, P.A.<br>615 EAST MAIN STREET, THURMONT, MD 21788   |  |  |  |
|   | 23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <u>Sepsis</u><br>Due to (or as a consequence of):<br><br>b. _____<br>Due to (or as a consequence of):<br><br>c. _____<br>Due to (or as a consequence of):<br><br>d. _____<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. _____<br>c. _____<br>d. _____ |  |   |   |  |  |  |  |
|   | 23b. Approximate Interval Between Onset and Death<br>72-96 Hrs.  |  |   |   |  |  |  |  |
| Physician<br>/Medical<br>Examiner   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Congestive Cardiomyopathy</u><br><u>Renal Failure</u><br><u>CO PD</u>   |  |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |
|   |  |  |   |   |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
|   |  |  |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
|   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |   |  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
| 28d. Describe how injury occurred   |  |  |   |   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)                       |  |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |   |   |  |  |  |  |
| 29b. Signature and title of certifier<br>   |  |  |   | 29c. License number<br>D26499                       |  | 29d. Date signed (Month, Day, Year)<br>1-29-96   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Ronald E. Miller, MD 4 Culwell Drive, Mt. Airy, Maryland 21771  |  |  |   |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>JAN 31 1996  |  |  |   | 32. Registrar's Signature<br>                       |  |  |  |  |



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04731

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>PAUL CARLTON FOXF, SR.</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>FEBRUARY</b> DAY <b>6</b> , YEAR <b>1996</b>   |  | 3. TIME OF DEATH<br><b>6:00 P M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>578-52-3444</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>53</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>SEPT. 25, 1942</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>WASHINGTON DC</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>37 BEACH DRIVE</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>MECHANICSVILLE</b>   |  |
| 9c. COUNTY OF DEATH<br><b>ST. MARY'S</b>  |  |  |  | 10a. STATE<br><b>MARYLAND</b>   |  | 10b. COUNTY<br><b>ST. MARY'S</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>MECHANICSVILLE</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>37 BEACH DRIVE</b>  |  |
| 10f. ZIP CODE<br><b>20659</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>UNITED STATES</b>   |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:                                       |  |  |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>  |  |  |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>   |  |  |  |
| 16. KIND OF BUSINESS/INDUSTRY<br><b>SIGNS</b>   |  |  |  | 17. FATHER'S NAME (First, Middle, Last)<br><b>JAMES N. FOXF</b>   |  |  |  |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>RUTH WILLIE RAMEY</b>   |  |  |  | 19a. INFORMANT'S NAME (Type/Print)<br><b>PAUL C. FOXF, JR.</b>  |  |  |  |
| 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>37 BEACH DRIVE, MECHANICSVILLE, MARYLAND 20659</b>  |  |  |  | 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  |  |  |
| 20b. PLACE AND DATE OF DISPOSITION (Name of facility, date)<br><b>HUNTT CREMATORY FEBRUARY 10, 1996</b>   |  |  |  | 20c. LOCATION — City or Town, State<br><b>WALDORF, MARYLAND</b>   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>BENJAMIN M. MATTHEWS M00658</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>THE HUNTT FUNERAL HOME, INC.<br/>P.O. BOX 156, WALDORF, MARYLAND 20604</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Probable Myocardial Infarction</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Liver disease</b>  |  |  |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>   |  |  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED<br><b>N/A</b>   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>N/A</b>   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>N/A</b>  |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>[Signature]</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>014285</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>FEBRUARY 8, 1996</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 13 1996</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |  |  |

1958-21

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04732

|  |  |  |  |   |   |  |   |   |  |   |  |   |  |
|--|--|--|--|---|---|--|---|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Wesley Thomas Franklin   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>February 01, 1996   |   | 3. TIME OF DEATH<br>9:01 P. M.   |   |   |  |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br>579-18-6584   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>92 YRS.   |   | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>August 4, 1903                             |   | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |  |   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Physicians Memorial Hospital   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>La Plata   |   |  | 9c. COUNTY OF DEATH<br>Charles  |   |  |   |  |   |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |   |  |   |   |  |   |  |   |  |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Charles   |  | 10c. CITY, TOWN OR LOCATION<br>Welcome  |   |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |  |   |  |   |  |
| 10e. STREET AND NUMBER<br>P.O. Box 247   |  |  | 10f. ZIP CODE<br>20693   |   |   | 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |   |   |  |   |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: Black                                    |   |  |   |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4   |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Agent |   |   | 16b. KIND OF BUSINESS/INDUSTRY<br>Insurance  |   |   |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Unknown   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Unknown  |   |  |   |   |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Elvira Barnes  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>14027 Reverend Boucher Place Upper Marlboro Maryland, 20772  |   |  |   |   |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Emory Chapel Cemetery Feb. 10, 1996   |  |   | 20c. LOCATION — City or Town, State<br>Nanjemoy, Maryland |  |   |   |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Lloyd M. Estep  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Adams Funeral Home Aquasco Maryland 20608   |   |  |   |   |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → Prostate cancer<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>{ Pulmonary edema<br>Congestive heart failure<br>myocardial infarction |  |  |  |   |   |  |   | Approximate interval between Onset and Death  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Respiratory failure, pneumonia<br>Alzheimer's Dementia   |  |  |  |   |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  |   |   |  |   |   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |   |  |   |   |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |   | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |   |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |   |  |   |   |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |   |  |   |   |  | 29c. LICENSE NUMBER<br>D-08370  |  | 29d. DATE SIGNED (Month, Day, Year)<br>2/1/96 |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Paul Pritchett, MD. 118 La Grange Avenue P.O. Box 1317 La Plata, Maryland 20646   |  |  |  |   |   |  |   |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>FEB 13 1996   |  | 32. REGISTRAR'S SIGNATURE<br>Julia Swisher-Randall   |  |   |   |  |   |   |  |   |  |   |  |

2500 69

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04733

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

BILLY JAMES FAULKNER

2. Date of Death  
Month Day Year

FEBRUARY 6, 1996 10 AM

3. Time of Death

4e. Facility Name (If not institution, give street and number)

165 DEFENSE HIGHWAY

4b. City, Town, or Location of Death

ANNAPOLIS

4c. County of Death

ANNE ARUNDEL

Funeral  
Director

5. Social Security Number

257-52-9676

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

63 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

MAY 25 1934

9. Birthplace (State or Foreign Country)

GEORGIA

Usual Residence of Decedent

10a. State

MD

10b. County

ANNE ARUNDEL

10c. City, Town or Location

ANNAPOLIS

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

165 DEFENSE HIGHWAY

10f. Zip Code

21401

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

9

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

LABORER

16b. Kind of Business/Industry

AMUSEMENTS

17. Father's Name (First, Middle, Last)

BILL FAULKNER

18. Mother's Name (First, Middle, Maiden Surname)

CORA VICK

19e. Informant's Name/Relationship (Type, Print)

EARL FAULKNER, BROTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9156 E- S AVENUE ANCHORAGE, ALASKA 99504

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

HILLCREST MEMORIAL GARDENS 2/9/96 ANNAPOLIS, MARYLAND

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

JOHN M. TAYLOR FUNERAL HOME, INC.  
147 DUKE OF GLOUCESTER ST. ANNAPOLIS, MD 21401

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Acute Cardiac Failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Arteriosclerotic Heart Disease

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 8 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 06054

29d. Date signed (Month, Day, Year)

2/6/96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

William P. Jones, MD

695 America Ct 21035

31. Date filed (Month, Day, Year)

FEB 09 1996

32. Registrar's Signature

State

Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04734

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ELTON FORRESTER</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>FEB. 5 1996</b>  |  | 3. TIME OF OATH<br><b>8:15 am</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216-36-7231</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>55</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>AUG. 21 1940</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>ANNE ARUNDEL MEDICAL CENTER</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>ANNAPOLIS</b>   |  | 9c. COUNTY OF DEATH<br><b>ANNE ARUNDEL</b>  |  |
| 10a. STATE<br><b>MARYLAND</b>  |  |  |  | 10b. COUNTY<br><b>ANNE ARUNDEL</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>ANNAPOLIS</b>   |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  | 10e. STREET AND NUMBER<br><b>1907 D COPELAND STREET</b>   |  |   |  |
| 10f. ZIP CODE<br><b>21401</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>US</b>  |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>BLACK</b>  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b><br>College (1-4 or 5+) <b>0</b>  |  | 18a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>BUS DRIVER</b>   |  | 18b. KIND OF BUSINESS/INDUSTRY<br><b>CITY OF ANNAPOLIS</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>LUTHER FORRESTER</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>CATHERINE GROSS</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>JOYCE ANN FORRESTER</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>637 BYWATER ROAD ANNAPOLIS, MD. 21401</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>EBENEZER CHURCH CEMETERY 2/10/96 GALESVILLE, MD.</b>   |  | 20c. LOCATION — City or Town, State   |  | 20d. DATE<br><b>2/10/96</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Larry H. Reese</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>REESE &amp; SONS MORTUARY, P.A.<br/>821 WEST ST. ANNAPOLIS, MD. 21401</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Human Immunodeficiency Virus Infection</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  | Approximate Interval Between Onset and Death<br><b>5 years</b>  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Cerebrovascular Disease</b>   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>David C. Barnes</i>  |  |  |  | 29c. LICENSE NUMBER<br><b>MD 732469</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>2/5/96</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>David C. Barnes 900 Bestgate Road Annapolis md 21401</i>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 09 1996</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |   |  |




00 1430

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04735

|  |  |                          |  |   |   |   |  |   |   |                                       |   |  |  |
|--|--|--------------------------|--|---|---|---|--|---|---|---------------------------------------|---|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>JAMES EDWARD FRIEND</b>   |  |                          |  | 2. DATE OF DEATH<br>MONTH <b>FEBRUARY</b> DAY <b>14</b> YEAR <b>1996</b>  |   |   |  | 3. TIME OF DEATH<br><b>8:45 A M</b>                             |   |                                       |   |  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>220-26-9489</b>  |  | 5. SEX<br><b>1 M 2 F</b> | 6. AGE (In yrs. last birthday)<br><b>68</b> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>      |   | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b> |   | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>MAR 17, 1927</b>           |                                       | 8. BIRTHPLACE (State or Foreign Country)<br><b>WV</b> |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>GARRETT COUNTY MEMORIAL HOSPITAL</b>  |  |                          |  |   | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>OAKLAND</b> |   |  |   |   | 9c. COUNTY OF DEATH<br><b>GARRETT</b> |   |  |  |
| RESIDENCE OF DECEDENT  |  |                          |  |   |   |   |  |   |   |                                       |   |  |  |
| 10a. STATE<br><b>MARYLAND</b>  |  |                          | 10b. COUNTY<br><b>GARRETT</b>  |   |   | 10c. CITY, TOWN OR LOCATION<br><b>SWANTON</b>   |  |   | 10d. INSIDE CITY LIMITS?<br><b>1 YES 2 NO</b>                           |                                       |   |  |  |
| 10e. STREET AND NUMBER<br><b>344 SWANTON ROAD</b>  |  |                          |  |   |   | 10f. ZIP CODE<br><b>21561</b>   |  |   | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                             |                                       |   |  |  |
| 11. MARITAL STATUS<br><b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>  |  |                          | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 YES 2 NO</b><br>IF YES, GIVE WAR OR DATES |   |   | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 YES 2 NO</b> Specify: |  |   | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b> |                                       |   |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>11 Elementary/Secondary (8-12) College (1-4 or 5+)</b>  |  |                          |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>CONTRACTOR</b>                      |   |   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>EXCAVATING</b>             |   |                                       |   |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>JAMES WILMER FRIEND</b>  |  |                          |  |   |   | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>VIOLA GERTRUDE BECKMAN</b>  |  |   |   |                                       |   |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>MRS. BETTY FRIEND</b>   |  |                          |  |   |   | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>344 SWANTON ROAD SWANTON, MD 21561</b>    |  |   |   |                                       |   |  |  |
| 20a. METHOD OF DISPOSITION<br><b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>  |  |                          |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>GEORGE CEMETERY 2/16</b>  |   |   |  | 20c. LOCATION — City or Town, State<br><b>SWANTON, MARYLAND</b> |   |                                       |   |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br> <b>M00167</b>   |  |                          |  |   |   | 22. NAME AND ADDRESS OF FACILITY<br><b>P.O. BOX 243 DURST FUNERAL HOME - OAKLAND, MD 21550</b>  |  |   |   |                                       |   |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiac Arrest (asystole)</b><br><b>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b><br>b. <b>Subdural hematoma</b><br>c.<br>d.<br><b>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</b><br><b>Congestive heart failure</b><br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN</b> |  |                          |  |   |   |   |  |   |   |                                       |   | Approximate Interval Between Onset and Death |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1 YES 2 NO</b>  |  |                          |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b><br>OTHER: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b> |   |   |  |   |   |                                       |   |  |  |
| 27. MANNER OF DEATH<br><b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</b>  |  |                          |  | 28a. DATE OF INJURY<br>(Month, Day, Year)   |   | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><b>1 YES 2 NO</b>                       |   | 28d. DESCRIBE HOW INJURY OCCURRED     |   |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |                          |  |   |   | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |                                       |   |  |  |
| 29a. CERTIFIER (Check only one)<br><b>1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b><br><b>2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>  |  |                          |  |   |   |   |  |   |   |                                       |   |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  |                          |  |   |   | 29c. LICENSE NUMBER<br><b>H26154</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>2/15/96</b>           |   |                                       |   |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>PAUL DANIEL MILLER, D.O. 2255 G.W. PLAZA RT. 135E, OAKLAND, MD 21550</b>   |  |                          |  |   |   |   |  |   |   |                                       |   |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 15 1996</b>  |  |                          |  | 32. REGISTRAR'S SIGNATURE<br>  |   |   |  |   |   |                                       |   |  |  |



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04736

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

|   |  |  |   |   |                                       |
|---|--|--|---|---|---------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Elmer Keiffer FOLAND, JR.</b>  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 25, 1996</b>               |   | 3. TIME OF DEATH<br><b>8:20 A. M.</b> |
| 4. SOCIAL SECURITY NUMBER<br><b>214-42-1406</b>   | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday)<br><b>53</b> YRS.   | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Oct. 22, 1942</b>                 | 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>   |                                       |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>5140 Doubs Road</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Adamstown</b>  |   | 9c. COUNTY OF DEATH<br><b>Frederick</b>   |                                       |
| RESIDENCE OF DECEDENT   |  |  |   |   |                                       |
| 10a. STATE<br><b>Maryland</b>   | 10b. COUNTY<br><b>Frederick</b>  | 10c. CITY, TOWN OR LOCATION<br><b>Adamstown</b>  |   | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |                                       |
| 10e. STREET AND NUMBER<br><b>5140 Doubs Road</b>  |  | 10f. ZIP CODE<br><b>21710</b>  |   | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                                       |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>30 Nov 60 to 30 Nov 64</b>  |   | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |                                       |
| 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |  |   |   |                                       |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>College</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Asssistant Superintendent</b>   |   | 16b. KIND OF BUSINESS/INDUSTRY<br><b>City Water Plant</b>   |                                       |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Elmer K. Foland, Sr.</b>  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mildred Bartgis</b> |   |                                       |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Connie L. Foland</b>   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5140 Doubs Road, Adamstown, Md. 21710</b>  |   |   |                                       |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Oak Hill Cemetery Jan. 29, 1996</b>  |   | 20c. LOCATION — City or Town, State<br><b>LeGore, Maryland</b>  |                                       |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Richard C. C. Basford</i> M00021  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Keeney and Basford Funeral Home<br/>106 East Church Street, Frederick, Md. 21701</b>  |   |   |                                       |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Adenocarcinoma of Lung</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>b. DUE TO (OR AS A CONSEQUENCE OF):</b><br><b>c. DUE TO (OR AS A CONSEQUENCE OF):</b><br><b>d. DUE TO (OR AS A CONSEQUENCE OF):</b> |  |  |   |   |                                       |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>  |  |  |   |   |                                       |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |                                       |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |   | 28b. TIME OF INJURY<br><b>M</b>   |                                       |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |   | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |                                       |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |   |   |                                       |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Robert S. Hughes</i>  |  | 29c. LICENSE NUMBER<br><b>D05111</b>   |   | 29d. DATE SIGNED (Month, Day, Year)<br><b>January 26, 1996</b>  |                                       |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Robert S. Hughes, M.D., 700 Montclair Ave., Frederick, Md. 21701</b>  |  |  |   |   |                                       |
| 31. DATE FILED (Month, Day, Year)<br><b>JAN 29 1996</b>   |  | 32. REGISTRAR'S SIGNATURE<br><i>Sheldon Randall</i>  |   |   |                                       |

28 00136

1000 1000 1000 1000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 96 04737

|   |   |  |   |  |  |  |  |  |   |  |
|---|---|--|---|--|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>Mary Freeze   |  |   |  | 2. Date of Death<br>Month Day Year<br>January 25, 1996   |  |  |  | 3. Time of Death<br>11:09 P.M.  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Frederick Memorial Hospital   |  |   |  | 4b. City, Town, or Location of Death<br>Frederick  |  |  |  | 4c. County of Death<br>Frederick  |  |
| Funeral<br>Director                           | 5. Social Security Number<br>209-12-9457  |  | 8. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>80 Yrs.  |  | If Under 1 Year<br>Months Days   |  | If Under 24 Hrs.<br>Hours Min.  |  |
|   | 6. Date of Birth (Month, Day, Year)<br>March 2, 1915  |  | 9. Birthplace (State or Foreign Country)<br>Maryland  |  | 10. Usual Residence of Decedent<br>10a. State<br>Maryland<br>10b. County<br>Frederick<br>10c. City, Town or Location<br>Thurmont<br>10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 10e. Street and Number<br>107 Frederick Road   |  | 10f. Zip Code<br>21788  |  |
| To Be Completed by Funeral Director           | 11. Merit Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:                                      |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12<br>College (1-4 or 5+)<br>Collage (1-4 or 5+)  |  |
|   | 16. Kind of Business/Industry<br>Self   |  | 17. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Restaurant                                |  | 18. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Restaurant   |  | 19. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Restaurant |  | 20. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Restaurant  |  |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br>William Russell Gehr   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Laura Elizabeth Shupp   |  |  |  | 19. Informant's Name/Relationship (Type, Print)<br>Gerald Freeze  |  |
|   | 20. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)<br>Blue Ridge Cemetery   |  |   |  | 21. Signature of Funeral Service Licensee<br>D. O. B. Mackay   |  | 22. Name and Address of Facility<br>Stauffer Funeral Home<br>104 E. Main Street, Thurmont, Maryland 21788              |  | 23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>CORONARY ARTERY DISEASE, Acute M.I. 3 days<br>Severe Chronic Obstructive Pulmonary Disease<br>Osteoporosis, Peripheral Vascular Disease |  |
| Physician<br>/Medical<br>Examiner             | 24. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Osteoporosis, Peripheral Vascular Disease   |  |   |  | 25. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown                                |  |  |  | 26. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
|   | 27. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |  | 28. Was the decedent referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  | 29. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                   |  | 28d. Describe how injury occurred   |  |
|   | 29. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br>Jane S. Grissom M.D.   |  | 29c. License number<br>D21944  |  | 29d. Date signed (Month, Day, Year)<br>1/26/96   |  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>Jane S. Grissom 1475 Taney Ave. Suite 204, Frederick, Md 21702  |  |
| State<br>Registrar                            | 31. Date filed (Month, Day, Year)<br>JAN 31 1996  |  |   |  | 32. Registrar's Signature<br>John Davidson-Randall   |  |  |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

1872



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04738

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

|  |  |  |   |   |  |  |   |   |  |   |  |
|--|--|--|---|---|--|--|---|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Dorothy Lee FAWLEY   |  |  |   | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>January 22, 1996  |  | 3. TIME OF DEATH<br>9:45 AM M  |   |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br>216-22-7958   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |   | 6. AGE (In yrs. last birthday)<br>68 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>Aug. 13, 1927                              |   | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>8015 Old Receiver Road   |  |  |   | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Frederick  |  |  | 9c. COUNTY OF DEATH<br>Frederick  |   |  |   |  |
| RESIDENCE OF DECEDENT  |  |  |   |   |  |  |   |   |  |   |  |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Frederick   |   | 10c. CITY, TOWN OR LOCATION<br>Frederick  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |   |  |   |  |
| 10e. STREET AND NUMBER<br>8015 Old Receiver Road   |  |  |   | 10f. ZIP CODE<br>21702  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   |   |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |   | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                     |   |   |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) College   |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Travel Agent |   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Travel Agency                                      |   |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>William Sherwood HILDEBRAND   |  |  |   | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Viola HANSHEW  |  |  |   |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Mrs. Karen Lee Banzhoff  |  |  |   | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>8015 Old Receiver Road, Frederick, Maryland 21702  |  |  |   |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 8 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery or crematorium or other place)<br>Rocky Springs Cemetery, Jan. 25, 1996   |   | DATE<br>Jan. 25, 1996   |  | 20c. LOCATION — City or Town, State<br>Frederick, Maryland                           |   |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Richard E. Gray M00255  |  |  |   | 22. NAME AND ADDRESS OF FACILITY<br>Keeney and Basford P.A. Funeral Home<br>106 East Church St., Frederick, Md. 21701   |  |  |   |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. possible brain metastases DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. extensive malignant melanoma 17 yrs DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |   |   |  |  |   | Approximate Interval Between Onset and Death<br>2 yrs   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>sepsis   |  |  |   |   |  |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>  |  |  |   |   |  |  |   |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |  |  |   |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |   | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |   | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Dr. P. Gregory Rausch MD   |  |  |   | 29c. LICENSE NUMBER<br>D 14626  |  | 29d. DATE SIGNED (Month, Day, Year)<br>Jan. 23, 1996  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Dr. P. Gregory Rausch MD 501 West Seventh Street, Frederick, Maryland 21701   |  |  |   |   |  |  |   |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>JAN 22 1996   |  |  |   | 32. REGISTRAR'S SIGNATURE<br>David A. Rausch  |  |  |   |   |  |   |  |

10-11-55

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

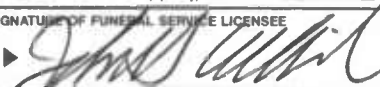


TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR  
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04739

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ALICE MARGARET FORTHUBER</b>   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Jan 30 96</b>  |  | 3. TIME OF DEATH<br><b>12 30 P M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216-01-8175</b>   |  | 5. SEX<br><b>1 M 2 F</b>  |  | 6. AGE (In yrs. last birthday)<br><b>77</b> YRS.<br>IF UNDER 1 YEAR: MONTHS DAYS HOURS MIN.<br>IF UNDER 24 HRS.                               |  |
| 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>2-9-18</b>   |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>MD.</b>  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>PENINSULA REGIONAL MEDICAL CENTER</b>                                    |  |
| 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>SALISBURY</b>   |  | 9c. COUNTY OF DEATH<br><b>WICOMICO</b>  |  | 10a. STATE<br><b>MD.</b>  |  |
| 10b. COUNTY<br><b>WORCESTER</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>BERLIN</b>  |  | 10d. INSIDE CITY LIMITS?<br><b>1 YES 2 NO</b>   |  |
| 10e. STREET AND NUMBER<br><b>103 TEAL CIRCLE</b>  |  | 10f. ZIP CODE<br><b>21811</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br><b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 YES 2 NO</b><br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 YES 2 NO</b> Specify: |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12 College (1-4 or 5+)</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>SALES REP.</b>            |  |
| 16b. KIND OF BUSINESS/INDUSTRY<br><b>RETAIL</b>   |  | 17. FATHER'S NAME (First, Middle, Last)<br><b>FRANK A. KING</b>   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>MARY VIOLA CHRISTY</b>  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>EMIL D. FORTHUBER</b>  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1637 OCEAN PINES BERLIN, MD., 21811</b>   |  | 20a. METHOD OF DISPOSITION<br><b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>                                   |  |
| 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>SALISBURY CREMATORY 2-1</b>   |  | 20c. LOCATION — City or Town, State<br><b>SALISBURY, MD.</b>  |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>ULLRICH FUNERAL HOME BERLIN, MD., 21811</b>  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CVA</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  | Approximate interval between Onset and Death<br><b>2 DAYS</b>   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>ASCVD</b>  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><b>1 YES 2 NO</b>   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1 YES 2 NO</b>  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1 YES 2 NO</b>   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b><br>OTHER: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>   |  | 27. MANNER OF DEATH<br><b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</b>                     |  |
| 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><b>1 YES 2 NO</b>   |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. CERTIFIER (Check only one)<br><b>1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b><br><b>2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>  |  | 29c. LICENSE NUMBER<br><b>A29168</b>  |  |
| 29d. DATE SIGNED (Month, Day, Year)<br><b>1/30/96</b>   |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Robert Allen 560 RIVER SIDE DR. A 204 Salisbury, md 21801</b>   |  | 31. DATE FILED (Month, Day, Year)<br><b>FEB 01 1996</b>   |  |
| 32. REGISTRAR'S SIGNATURE<br>  |  |   |  |   |  |

1001

SECTION

SECTION

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 96 04740

|   |  |  |   |   |  |  |   |                                   |  |
|---|--|--|---|---|--|--|---|-----------------------------------|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Ruth Clark Goodwin   |  |   |   | 2. Date of Death<br>Month Day Year<br>Feb 2, 1996  |  | 3. Time of Death<br>1:30pm                                      |                                   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Montgomery General Hospital  |  |   |   | 4b. City, Town, or Location of Death<br>Olney  |  | 4c. County of Death<br>Montgomery                               |                                   |  |
| Funeral<br>Director   | 5. Social Security Number<br>578-24-4810   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>87 Yrs.   | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>Jan 7, 1909   | 9. Birthplace (State or Foreign Country)<br>Washington DC       |                                   |  |
|   | Usual Residence of Decedent  |  |   |   |  |  |   |                                   |  |
| To Be Completed by Funeral Director   | 10a. State<br>Virginia   | 10b. County<br>Fairfax   | 10c. City, Town or Location<br>Falls Church   |   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   |                                   |  |
|   | 10e. Street and Number<br>2916 Cleave Drive  |  |   | 10f. Zip Code<br>22042  |  | 10g. Citizen of What Country?<br>USA   |   |                                   |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:         |  | 14. Race: American Indian, Black, White, etc.<br>Specify: White |                                   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+)  |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker  |  | 16b. Kind of Business/Industry<br>Own Home   |   |                                   |  |
|   | 17. Father's Name (First, Middle, Last)<br>Herbert F. Clark  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Florence B. Arnold  |  |   |                                   |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br>H. David Clark Nephew  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>18816 Rolling Acres Way Olney MD 20832  |  |   |                                   |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Franklin Cemetery   |   | 20c. Location - City or Town, State<br>Franklin, NH  |  | 20d. Date   |                                   |  |
|   | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |  |   |   | 22. Name and Address of Facility<br>Everly-Colonial FH 6161 Leesburg Pike<br>Falls Church, Va. 22044   |  |   |                                   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. Sepsis<br>Due to (or as a consequence of):<br>b. Pneumonia<br>Due to (or as a consequence of):<br>c. Urinary Tract Infection<br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   | Approximate Interval Between Onset and Death<br>5 days<br>5 days<br>5 days   |  |   |                                   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |   |                                   |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |   |                                   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |   |                                   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)  |   | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No               |   | 28d. Describe how injury occurred |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |                                   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |   |   |  |  |   |                                   |  |
| 29b. Signature and title of certifier<br><i>[Signature]</i> M.D.  |  |  |   | 29c. License number<br>D18726   |  | 29d. Date signed (Month, Day, Year)<br>February 2, 1996  |   |                                   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>1811 Prince Philip Dr, Olney, MD 20832  |  |  |   |   |  |  |   |                                   |  |
| 31. Date filed (Month, Day, Year)<br>FEB 21 1996  |  |  |   | 32. Registrar's Signature<br><i>[Signature]</i>   |  |  |   |                                   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Amended Item 19b. 02/14/96 502 Arch Street  
Amended Item 10e. 02/14/96 502 Arch Street

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 047411

|   |  |  |   |   |  |  |  |   |  |   |  |
|---|--|--|---|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Louis Victor George   |  |  |   | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>February 8 1996   |  |  |  | 3. TIME OF DEATH<br>08:16 a.m.  |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br>175-01-0131  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br>84 YRS. | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>July 23, 1911   |  | 8. BIRTHPLACE (State or Foreign Country)<br>Pennsylvania                             |  |   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Laurelwood Nursing Center   |  |  |   | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Elkton   |  |  |  | 9c. COUNTY OF DEATH<br>Cecil  |  |   |  |
| 10a. STATE<br>Maryland  |  | 10b. COUNTY<br>Cecil   |   | 10c. CITY, TOWN OR LOCATION<br>Perryville   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO       |  |   |  |
| 10e. STREET AND NUMBER<br>502 Arch Street   |  |  |   | 10f. ZIP CODE<br>21903  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>United States                                       |  |   |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |   | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                     |  |   |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>4  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Pharmacist  |   | 16b. KIND OF BUSINESS/INDUSTRY<br>Sales:<br>Retail Pharmaceuticals  |  |  |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Ernest George  |  |  |   | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Mary Kulik   |  |  |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>T. Geneva George  |  |  |   | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>502 Arch Street<br>502 George Street, Perryville, MD 21903   |  |  |  |   |  |   |  |
| 20a. MANNER OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Round Hill Cemetery   |   | DATE<br>2/11  |  | 20c. LOCATION — City or Town, State<br>Elizabeth, Pennsylvania                       |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |   | 22. NAME AND ADDRESS OF FACILITY<br>Crouch Funeral Home<br>127 South Main Street, North East MD 21901   |  |  |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CARCINOMA OF LUNG.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Approximate interval Between Onset and Death<br>1 MONTH<br>Sequently ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |   |   |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>CHRONIC OBSTRUCTIVE LUNG DISEASE<br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |   |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |  |  |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |   | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE NOW INJURY OCCURRED   |  |   |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |   |   |  |  |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |   |   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  |  |   | 29c. LICENSE NUMBER<br>D45344   |  | 29d. DATE SIGNED (Month, Day, Year)<br>2-8-96  |  |   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Suresh M. Dhanjani, M.D. P.O. Box 781, Perryville, Md. 21903   |  |  |   |   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>FEB 09 1996  |  |  |   | 32. REGISTRAR'S SIGNATURE<br>   |  |  |  |   |  |   |  |

10500 26



**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

Reg. No. **96 04742**

**Physician  
/Medical  
Examiner**

**Funeral  
Director**

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>JOHN GILL</b>  |  |   |  | 2. Date of Death<br>Month <b>February</b> Day <b>04</b> Year <b>1996</b>   |  | 3. Time of Death<br><b>2330 (1130pm)</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>THE JOHNS HOPKINS HOSPITAL</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE CITY</b>  |  | 4c. County of Death<br><b>Baltimore City</b>   |  |
| 5. Social Security Number<br><b>577 58 4327</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>53</b> Yrs. | If Under 1 Year<br>Months <b>0</b> Days <b>0</b>   | If Under 24 Hrs.<br>Hours <b>0</b> Min. <b>0</b> | 8. Date of Birth (Month, Day, Year)<br><b>Jan. 7, 1943</b>                                     |  |
| 9. Birthplace (State or Foreign Country)<br><b>Wash., D.C.</b>  |  |   |  |  |  |  |  |
| Usual Residence of Decedent   |  |   |  |  |  |  |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Calvert</b>   |  | 10c. City, Town or Location<br><b>Huntingtown</b>  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br><b>1530 Live Oak Drive</b>  |  |   |  | 10f. Zip Code<br><b>20639</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>                        |  |
| 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>warehouse supervisor</b>   |  | 16b. Kind of Business/Industry<br><b>food services</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>John Charles Gill, Sr.</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Florence Klock</b>   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Margaret L. Gill / wife</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>same as # 10 above</b>   |  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b>   |  | Date<br><b>2/6/96</b>  |  | 20c. Location - City or Town, State<br><b>Alexandria, VA</b>                                   |  |
| 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>Rausch Funeral Home, P.A. Owings, MD 20736</b>  |  |  |  |

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician  
/Medical  
Examiner**

|   |                                     |  |
|---|-------------------------------------|--|
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. |                                     | Approximate Interval Between Onset and Death |
| Immediate Cause (Final disease or condition resulting in death)   | a. <b>Brain stem infarction</b>     |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  | b. <b>Basilar Artery Thrombosis</b> |  |
|   | c. _____                            |  |
|   | d. _____                            |  |

|  |  |  |  |
|--|--|--|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hyperlipidemia, Hypertension, Coronary Artery Disease</b> |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |
|  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |

|   |  |   |  |
|---|--|---|--|
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day Year)   |  |
|   |  | 28b. Time of Injury<br><b>M</b>   |  |
|   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
|   |  | 28d. Describe how injury occurred   |  |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |
|   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |

|  |  |  |  |
|--|--|--|--|
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br>            |  |
|  |  | 29c. License number<br><b>040041</b>                 |  |
|  |  | 29d. Date signed (Month, Day, Year)<br><b>2-4-96</b> |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Michael A Williams 600 N. Wolfe Street, Meyer 8-140</b>   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB - 9 1996</b>   |  | 32. Registrar's Signature<br>                        |  |

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

**State  
Registrar**



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR   |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 96 04743  |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)   |  | 2. DATE OF DEATH   |  |   |  | 3. TIME OF DEATH  |  |
| Philip R Goodnow   |  | MONTH 2 DAY 7 YEAR 1996  |  |   |  | 08:11 M   |  |
| 4. SOCIAL SECURITY NUMBER  |  | 5. SEX   |  | 6. AGE (In yrs. last birthday)  |  | 7. DATE OF BIRTH  |  |
| 235-20-5889  |  | 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 75 YRS.   |  | 08-04-1920 MD   |  |
| 9a. FACILITY NAME (If not institution, give street and number)   |  | 9b. CITY, TOWN OR LOCATION OF DEATH  |  |   |  | 9c. COUNTY OF DEATH   |  |
| Anne Arundel Medical Ctr.  |  | Annapolis  |  |   |  | Anne Arundel  |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |  |
| 10a. STATE   |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION   |  | 10d. INSIDE CITY LIMITS?  |  |
| MD   |  | Anne Arundel   |  | Annapolis   |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER   |  |  |  | 10f. ZIP CODE   |  | 10g. CITIZEN OF WHAT COUNTRY?   |  |
| 1200 Chrisland Ct.   |  |  |  | 21403   |  | USA   |  |
| 11. MARITAL STATUS   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN?  |  | 14. RACE — American Indian, Black, White, etc.                          |  |
| 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |  | 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>WWII   |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:              |  | Specify:<br>White   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |
| Elementary/Secondary (0-12)<br>10  |  | College (1-4 or 5+)  |  | Stockroom   |  | Shipbuilder   |  |
| 17. FATHER'S NAME (First, Middle, Last)  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)   |  |   |  |
| William M Goodnow  |  |  |  | Annie B Castor  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |  |   |  |
| Barbara Parrish  |  |  |  | 1200 Chrisland Ct. Annapolis, MD. 21401   |  |   |  |
| 20a. METHOD OF DISPOSITION   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)  |  | DATE  |  | 20c. LOCATION — City or Town, State                                     |  |
| 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | MD Veterans Cem. 2/9   |  | 2/9   |  | Crownsville, MD   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  |  |  |  | 22. NAME AND ADDRESS OF FACILITY  |  |   |  |
|  |  |  |  | Barranto & Sons Funeral Home<br>495 Ritchie Hwy. Severna Park MD 21146                        |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiac arrest.   |  |  |  |   |  |   |  |
| b. ventricular fibrillation.   |  |  |  |   |  |   |  |
| c. dilated cardiomyopathy  |  |  |  |   |  |   |  |
| d. coronary disease  |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |   |  |   |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |   |  |   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>  |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)  |  |   |  |   |  |
|  |  | HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY   |  | 28c. INJURY AT WORK?  |  |
| 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide   |  |  |  | M   |  | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO            |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                  |  |   |  |
|  |  |  |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  |  |  |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)                                     |  |
| Barbara L. Bean MD   |  |  |  | D39497  |  | 2/7/96  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  |  |  |  |   |  |   |  |
| BARBARA L. BEAN, Suite 300, 900, Bestgate Road, Annapolis MD 21401   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)  |  | 32. REGISTRAR'S SIGNATURE  |  |   |  |   |  |
| FEB 09 1996  |  |  |  |   |  |   |  |

245/10 27

25 26

27 28

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR  |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 96 04744  |  |   |  |                                      |  |  |  |
|---|--|--|--|---|--|--|--|---|--|---|--|--------------------------------------|--|--|--|
| CERTIFICATE OF DEATH  |  |  |  | REG. NO.  |  |  |  |   |  |   |  |                                      |  |  |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ROSEANNE GUTIERREZ</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>FEB.</b> DAY <b>2</b> YEAR <b>1996</b>   |  |  |  | 3. TIME OF DEATH<br><b>1:10P</b>  |  |   |  |                                      |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>582-38-6076</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>61</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>NOV. 19, 1934</b>                          |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>PUERTO RICO</b>  |  |   |  |                                      |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>907 COLONY DRIVE</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>SALISBURY</b>   |  |  |  | 9c. COUNTY OF DEATH<br><b>WICOMICO</b>  |  |   |  |                                      |  |  |  |
| 10a. STATE<br><b>MD.</b>  |  | 10b. COUNTY<br><b>WICOMICO</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>SALISBURY</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO       |  |   |  |                                      |  |  |  |
| 10e. STREET AND NUMBER<br><b>907 COLONY DRIVE</b>   |  |  |  | 10f. ZIP CODE<br><b>21801</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  |                                      |  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: <b>PUERTO RICAN</b> |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                                   |  |   |  |                                      |  |  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b></b>   |  | 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>HOUSEWIFE</b>   |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>OWN HOME</b>                                    |  |   |  |   |  |                                      |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>JUAN BARTOLOMEI</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>FRANCISCA RAMOS</b>   |  |  |  |   |  |   |  |                                      |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>RAY GUTIERREZ</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>907 COLONY DRIVE, SALISBURY, MD. 21801</b>  |  |  |  |   |  |   |  |                                      |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>MD. VETERAN CEMETERY</b>   |  | DATE<br><b>2/5</b>  |  | 20c. LOCATION — City or Town, State<br><b>HURLOCK, MD.</b>                           |  |   |  |   |  |                                      |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Sigald C. Brunch</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>BOUNDS FUNERAL HOME, SALISBURY, MD. 21804</b>  |  |  |  |   |  |   |  |                                      |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Carcinoma of the Ovary</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Approximate interval Between Onset and Death<br><b>3.5 years</b> |  |  |  |   |  |  |  |   |  |   |  |                                      |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>  |  |  |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |                                      |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |   |  |   |  |                                      |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |                                      |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |   |  |                                      |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |  |   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>J. E. Martin, M.D.</i>  |  | 29c. LICENSE NUMBER<br><b>030490</b> |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>5 FEB 1996</b> |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>James E. Martin, M.D., 145 E. Carroll St., Salisbury, MD.</b>   |  |  |  |   |  |  |  |   |  |   |  |                                      |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 05 1996</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson Randall</i>  |  |  |  |   |  |   |  |                                      |  |  |  |

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR   |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 96 04745  |  |   |  |
|---|--|--|--|---|--|--|--|---|--|---|--|
| CERTIFICATE OF DEATH  |  |  |  | REG. NO.  |  |  |  |   |  |   |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br>LaRue Rosella Green   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>Feb 6, 1996   |  |  |  | 3. TIME OF DEATH<br>10:43 A M   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br>214-36-9599  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>76 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>May 9, 1919                                   |  | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Long View Nursing Home  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Manchester   |  |  |  | 9c. COUNTY OF DEATH<br>Carroll  |  |   |  |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |  |  |   |  |   |  |
| 10a. STATE<br>Maryland  |  | 10b. COUNTY<br>Carroll   |  | 10c. CITY, TOWN OR LOCATION<br>Hampstead  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO       |  |   |  |
| 10e. STREET AND NUMBER<br>123 Hanover Pike  |  |  |  | 10f. ZIP CODE<br>21074  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White  |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>11   |  | 15b. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Housewife   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Own Home  |  |  |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Charles Merryman   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Bernice Sparks   |  |  |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Shirlee Elseroad  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1717 Emory Road, Reisterstown, MD 21136  |  |  |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Emory Cemetery  |  | DATE<br>2/9   |  | 20c. LOCATION — City or Town, State<br>Reisterstown, MD                              |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Kevin M. Reider  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Eline Funeral Home<br>934 S Main St, Hampstead, MD 21074  |  |  |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → Stroke<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |  |  | Approximate Interval Between Onset and Death<br>2 years   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  |   |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURED  |  |   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Steven Shaffer  |  |   |  | 29c. LICENSE NUMBER<br>D33165  |  | 29d. DATE SIGNED (Month, Day, Year)<br>2/6/96   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Steven Shaffer 2111 Hanover Rte Hampstead MD 21074   |  |  |  |   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>FEB - 7 1996   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>John Shuckor-Rodell  |  |  |  |   |  |   |  |

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR  |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 96 04746  |  |   |  |   |  |   |  |
|--|--|--|--|--|--|--|--|---|--|---|--|---|--|---|--|
| CERTIFICATE OF DEATH   |  |  |  | REG. NO.   |  |  |  |   |  |   |  |   |  |   |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Mary Frances GAVER   |  |  |  | 2. DATE OF DEATH<br>January 30, 1996   |  |  |  | 3. TIME OF DEATH<br>5:52 AM   |  |   |  |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br>219-76-2091   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>89 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAY                          |  | IF UNDER 24 HRS.<br>HOURS MIN.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>June 17, 1906 |  | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Frederick Memorial Hospital  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Frederick   |  |  |  | 9c. COUNTY OF DEATH<br>Frederick  |  |   |  |   |  |   |  |
| RESIDENCE OF DECEDENT  |  |  |  |  |  |  |  |   |  |   |  |   |  |   |  |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Frederick   |  | 10c. CITY, TOWN OR LOCATION<br>Frederick   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |   |  |   |  |   |  |
| 10e. STREET AND NUMBER<br>644 Wilson Place   |  |  |  | 10f. ZIP CODE<br>21702   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |   |  |   |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                                    |  |   |  |   |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Homemaker                       |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Own Home   |  |  |  |   |  |   |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Emory Filmore SLIFER  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Lola Eve WILLARD  |  |  |  |   |  |   |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Mr. Charles F. Trunk   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>506 Fairview Avenue, Frederick, Maryland 21701  |  |  |  |   |  |   |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Zion Lutheran Cemetery, Feb. 2, 1996                          |  |  |  | 20c. LOCATION — City or Town, State<br>Middletown, Md. |  |   |  |   |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Richard E. Hraf MO0255  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Keeney and Basford P.A. Funeral Home<br>106 East Church St., Frederick, Md. 21701  |  |  |  |   |  |   |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. cerebrovascular disease<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. dementia<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. seizure disorder<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. hypertension |  |  |  |  |  |  |  |   |  |   |  | Approximate Interval Between Onset and Death<br>4-5 yrs<br>5 yrs<br>6 yrs                                 |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>osteoporosis   |  |  |  |  |  |  |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>  |  |  |  |  |  |  |  |   |  |   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |   |  |   |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  |  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M                               |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  | 28d. DESCRIBE HOW INJURY OCCURRED                       |  |   |  |   |  |
|  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                        |  |   |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |  |  |   |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>A. Meyerhoff MD   |  |  |  | 29c. LICENSE NUMBER<br>D43408  |  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br>Jan. 31, 1996  |  |   |  |   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>A. Meyerhoff MD 300 West 9th St Frederick, MD   |  |  |  |  |  |  |  |   |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>FEB 02 1996   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>John H. H. H. H.  |  |  |  |   |  |   |  |   |  |   |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 96 04747

|  |   |                          |   |  |   |   |  |  |  |                                   |  |
|--|---|--------------------------|---|--|---|---|--|--|--|-----------------------------------|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>EVELYN ELIZABETH GAVER                            |                          |   |  |   |   | 2. Date of Death<br>Month Day Year<br>January 25, 1996 |  | 3. Time of Death<br>8:00 a.m.                        |                                   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Frederick Memorial Hospital |                          |   |  |   |   | 4b. City, Town, or Location of Death<br>Frederick      |  | 4c. County of Death<br>Frederick                     |                                   |  |
| Funeral<br>Director  | 5. Social Security Number<br>216-48-6767  |                          | 8. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>83 Yrs.   |   | If Under 1 Year<br>Months Days                         |  | 8. Date of Birth (Month, Day, Year)<br>June 23, 1912 |                                   |  |
|  |   |                          |   |  |   |   |  |  | 9. Birthplace (State or Foreign Country)<br>Md.      |                                   |  |
| Usual Residence of Decedent  |   |                          |   |  |   |   |  |  |  |                                   |  |
| 10a. State<br>Md.  |   | 10b. County<br>Frederick |   | 10c. City, Town or Location<br>Middletown  |   |   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |                                   |  |
| 10e. Street and Number<br>8343 Myersville Rd.  |   |                          |   | 10f. Zip Code<br>21769   |   |   | 10g. Citizen of What Country?<br>U.S.A.                |  |  |                                   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   |                          | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                   |  |                                   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 11 Collage (1-4or 5+)   |   |                          |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>housewife |   |   |  | 16b. Kind of Business/Industry<br>own home   |  |                                   |  |
| 17. Father's Name (First, Middle, Last)<br>Charles Richard Holter  |   |                          |   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Ura Viola Lucretia Ahalt   |  |  |  |                                   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>C. Wayne E. Gaver (Son)  |   |                          |   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>8343 Myersville Rd., Middletown, Md. 21769 |  |  |  |                                   |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   |                          |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Reformed Cemetery                            |   | Date<br>1/28  |  | 20c. Location - City or Town, State<br>Middletown, Md.   |  |                                   |  |
| 21. Signature of Funeral Service Licensee<br>  |   |                          |   |  |   | 22. Name and Address of Facility<br>Donald B. Thompson Funeral Home<br>31 E. Main St., Middletown, Md. 21769                                |  |  |  |                                   |  |
| 23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. RENAL FAILURE<br>Due to (or as a consequence of):<br>b. CONGESTIVE HEART FAILURE<br>Due to (or as a consequence of):<br>c. ATRIAL FIBRILLATION<br>Due to (or as a consequence of):<br>d. CORONARY ARTERY DISEASE<br><br>Approximate Interval Between Onset and Death<br>YEARS<br>YEARS<br>YEARS<br>YEARS |   |                          |   |  |   |   |  |  |  |                                   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>HYPERTENSION<br>ADULT ONSET DIABETES MELLITUS  |   |                          |   |  |   |   |  |  |  |                                   |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |   |                          |   |  |   |   |  |  |  |                                   |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |                          |   |  |   |   |  |  |  |                                   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |                          |   |  |   |   |  |  |  |                                   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |                          |   |  |   |   |  |  |  |                                   |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |   |                          |   |  |   |   |  |  |  |                                   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |   |                          |   | 28a. Date of Injury (Month, Day, Year)   |   | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No               |  | 28d. Describe how injury occurred |  |
|  |   |                          |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                 |   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                       |  |                                   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   |                          |   |  |   |   |  |  |  |                                   |  |
| 29b. Signature and title of certifier<br>  |   |                          |   |  |   | 29c. License number<br>D20488   |  | 29d. Date signed (Month, Day, Year)<br>1-25-96   |  |                                   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>JAMES L. KOESSLER MD PO BOX 17 MIDDLETOWN, MD - 21769  |   |                          |   |  |   |   |  |  |  |                                   |  |
| 31. Date filed (Month, Day, Year)<br>JAN 29 1996   |   |                          |   | 32. Registrar's Signature<br>  |   |   |  |  |  |                                   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

1944

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the investigation.

2. The second part of the report is a detailed description of the experimental methods used in the study. It includes a description of the apparatus, the procedures followed, and the data collected.

3. The third part of the report is a discussion of the results of the study. It compares the experimental findings with the theoretical predictions and discusses the implications of the results.

4. The fourth part of the report is a conclusion and a summary of the findings. It states the main results of the study and provides a brief overview of the conclusions drawn from the data.

5. The fifth part of the report is a list of references. It includes a list of the books, articles, and other sources used in the study.

6. The sixth part of the report is an appendix. It contains additional information that is not included in the main body of the report, such as raw data, calculations, and other supporting material.

7. The seventh part of the report is a bibliography. It lists the sources of information used in the study, including books, articles, and other references.

8. The eighth part of the report is a list of figures. It includes a list of the figures included in the report, such as graphs, tables, and other visual aids.

96-628-510

B.K.S

ITEMS: 23 PART I, 27,

28a-f, PER MEO FILM G-732  
2/22/96 t.t

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04748

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

EDWARD D. HEDRICK

2. Date of Death

Month

Day

Year

FEB. 09, 1996

3. Time of Death

1218PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

1720 ST. PAUL STREET APT. #2

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

5. Social Security Number

215-58-3846

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

42 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

8/13/53

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

1720 St. Paul Street Apt. 2

10f. Zip Code

21202

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

Collega (1-4or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Nurse

16b. Kind of Business/Industry

Health Care

17. Father's Name (First, Middle, Last)

Edward V. Hedrick

18. Mother's Name (First, Middle, Maiden Surname)

Evangeline Downing

19a. Informant's Name/Relationship (Type, Print)

Carolyn J. Zdziera

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

558 Crestwood St. Leesburg, VA 22075

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metropolitan Crematory 2/12 Alexandria, VA

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility  
Colonial Funeral Home of  
Leesburg Leesburg, VA 2207523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)a. **NARCOTIC INTOXICATION**

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☒ Pending Investigation  
6 ☒ Could not be determined

28a. Date of Injury

(Month, Day Year)

FOUND 2/9/96

28b. Time of

FOUND 12:00 A M

28c. Injury at

Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

UNKNOWN

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

FOUND AT HOME

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

1720 ST. PAUL ST. APT. 2 BALTIMORE, MD. 21202

29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

FEBRUARY 10, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARGARET D. O'NEIL 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

FEB 21 1996

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04749

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Melvin Charles Humphrey

2. Date of Death

Month

Day

Year

3. Time of Death

12:58 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

214- 09- 3132

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

81

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

August 31, 1914

9. Birthplace (State or Foreign Country)

Hagerstown Md.

Usual Residence of Decedent

10a. State

Md.

10b. County

Washington

10c. City, Town or Location

Boonsboro

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2 South Main St.

10f. Zip Code

21713

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Labor

16b. Kind of Business/Industry

Gas Station Attendant

17. Father's Name (First, Middle, Last)

Charles W. Humphrey

18. Mother's Name (First, Middle, Maiden Surname)

Jennie Mae Norris

19a. Informant's Name/Relationship (Type, Print)

Jane M. Humphrey

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2 S. Main St., Boonsboro, MD 21713

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Boonsboro Cemetery

Date

2/5/96

20c. Location - City or Town, State

Boonsboro, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

John H. Bast Jr. BAST FUNERAL HOME

7606 Old National Pike

Boonsboro, MD 21713

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MALIGNANT METASTATIC MELANOMA.

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

4 MONTHS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ASTROCYTOMA BRAIN

CHRONIC OBSTRUCTIVE LUNG DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D44996

29d. Date signed (Month, Day, Year)

JANUARY 31, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ZAFAR MAJID 20311 LAPPANS RD BOONSBORO MD 21713

31. Date filed (Month, Day, Year)

FEB 11 1996

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 96 04750

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARGARET

R.

HARRISON

2. Date of Death  
Month Day Year

Feb. 2 1996

3. Time of Death

11:40 p

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Memorial Hospital at Easton

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

5. Social Security Number

218-20-8674

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

70

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

DEC. 4, 1925

9. Birthplace (State or Foreign  
Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

TALBOT

10c. City, Town or Location

EASTON

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

18 JUDAS STREET

10f. Zip Code

21601

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

OFFICE CLERK

16b. Kind of Business/Industry

VENDING BUSINESS

17. Father's Name (First, Middle, Last)

CLARENCE RUSS

18. Mother's Name (First, Middle, Maiden Sumama)

BEULAH CHEEZUM

19a. Informant's Name/Relationship (Type, Print)

GERALD G. NEWELL/NEPHEW

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

111 PROSPECT AVE., EASTON, MD 21601

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

SPRING HILL CEMETERY 2-7

Date

20c. Location - City or Town, State

EASTON, MD

21. Signature of Funeral Service Licensee

D. E. Newnam III C.F.S.P.

22. Name and Address of Facility

FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME  
200 S. HARRISON ST., EASTON, MD23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Chronic hemolytic Anemia

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

10+ yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Small bowel Obstruction  
Bilateral Bronchopneumonia  
Addison's Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner as stated.

29b. Signature and title of certifier

William H. Wood, Jr. MD

29c. License number

1508715

29d. Date signed (Month, Day, Year)

2/4/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WILLIAM H. WOOD, JR., M.D., 506 IDLEWILD AVENUE, EASTON, MD 21601

31. Date filed (Month, Day, Year)

FEB 08 1996

32. Registrar's Signature

John Davidson Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a show  
any injury or other traumatic event, the Medical Examiner must be notified at  
202-698-9028.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

1. The first part of the report deals with the general situation of the country and the progress of the work during the year.

2. The second part of the report deals with the results of the work during the year.

3. The third part of the report deals with the financial statement of the year.

4. The fourth part of the report deals with the general remarks of the year.

5. The fifth part of the report deals with the general remarks of the year.

6. The sixth part of the report deals with the general remarks of the year.

7. The seventh part of the report deals with the general remarks of the year.

8. The eighth part of the report deals with the general remarks of the year.

9. The ninth part of the report deals with the general remarks of the year.

10. The tenth part of the report deals with the general remarks of the year.

11. The eleventh part of the report deals with the general remarks of the year.

12. The twelfth part of the report deals with the general remarks of the year.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04751

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARGARET KATHERINE

Hunt

2. Date of Death

Month Day Year  
Feb. 4, 1996

3. Time of Death

6:20 PM

4a. Facility Name (If not institution, give street and number)

Memorial Hospital at Easton

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

Funeral  
Director

5. Social Security Number

220-01-4986

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

91

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

JULY 2, 1904

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

TALBOT

10c. City, Town or Location

EASTON

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

606 NORTH WASHINGTON STREET

10f. Zip Code

21601

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

6

Collage (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

HOUSEWIFE

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

JOHN WILLIAM HADDAWAY

18. Mother's Name (First, Middle, Maiden Surname)

ANN JONES

19a. Informant's Name/Relationship (Type, Print)

WILLIAM C. HUNT/ SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

29192 RABBITT HILL RD., EASTON, MD 21601

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

WOODLAWN MEMORIAL PARK 2-8 EASTON, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

JOHN R. MERLERO, LFS

22. Name and Address of Facility

FELLOWS, HELFENBEIN, & NEWMAN FUNERAL HOME  
200 S. HARRISON ST., EASTON, MD 21601

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. UROSEPSIS

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

72°

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ALZHEIMERS

Due to (or as a consequence of):

YEARS

c. BED RIDDEN STATE

Due to (or as a consequence of):

YEARS

d. MALNUTRITION

YEARS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

JOHN R. CONDIT, JR.

29c. License number

H41416

29d. Date signed (Month, Day, Year)

2/5/96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

JOHN R. CONDIT, JR., DO, 403 MARVEL COURT, EASTON, MD 21601

31. Date filed (Month, Day, Year)

FEB 08 1996

32. Registrar's Signature

John Davidson Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

10/1/77

Dear Mr. [Name] [Address] [City] [State] [Zip]

Re: [Subject]

I am writing to you regarding [Subject]

[Text]

[Text]

[Text]

[Text]

[Text]

[Text]

[Text]

[Text]

[Text]

[Text]

[Text]

[Text]

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1 - FOR STATE REGISTRAR  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE                    |  |   |  | 96 04752   |  |
|--|--|--|--|---|--|--|--|
| CERTIFICATE OF DEATH   |  |  |  | REG. NO.  |  |  |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Ruby Estelle Hillis  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>01 30 96  |  | 3. TIME OF DEATH<br>8:10PM M                         |  |
| 4. SOCIAL SECURITY NUMBER<br>212-07-9673   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>81 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>June 11, 1914 |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Maryland   |  |  |  | 9. FACILITY NAME (If not institution, give street and number)<br>William Hill Health Care Center  |  |  |  |
| 10. CITY, TOWN OR LOCATION OF DEATH<br>Cambridge, Maryland   |  |  |  | 11. COUNTY OF DEATH<br>Dorchester   |  |  |  |
| 12. RESIDENCE OF DECEDENT<br>10a. STATE: Maryland 10b. COUNTY: Dorchester 10c. CITY, TOWN OR LOCATION: Cambridge 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 13. STREET AND NUMBER<br>2601 Lance Drive   |  |  |  |
| 14. ZIP CODE<br>21613  |  |  |  | 15. CITIZEN OF WHAT COUNTRY?<br>USA   |  |  |  |
| 16. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |  |  |  | 17. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES   |  |  |  |
| 18. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  |  |  | 19. RACE — American Indian, Black, White, etc. Specify: White   |  |  |  |
| 20. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4   |  |  |  | 21. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Housewife  |  |  |  |
| 22. KIND OF BUSINESS/INDUSTRY  |  |  |  | 23. FATHER'S NAME (First, Middle, Last)<br>Rueben McQuay  |  |  |  |
| 24. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Fannie Morris   |  |  |  | 25. INFORMANT'S NAME (Type/Print)<br>Sandra Lee Hayden  |  |  |  |
| 26. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2601 Lance Drive, Cambridge, Maryland 21613  |  |  |  | 27. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  |
| 28. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Bozman Cemetery Feb 9, 1996  |  |  |  | 29. LOCATION — City or Town, State<br>Bozman, MD.   |  |  |  |
| 30. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Harrison E. Leonard   |  |  |  | 31. NAME AND ADDRESS OF FACILITY<br>Harrison E. Leonard Funeral Home<br>312 South Talbot St., St. Michaels, MD. 21663   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiac Arrhythmia 1 day<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. Hypertensive Cardiovascular disease 10 yrs<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. Chronic Dehydrated State 3 yrs<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. Dementia 3 yrs<br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Breast Cancer<br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> |  |  |  |   |  |  |  |
| 24. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 25. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |
| 26. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 27. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 28. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  |  |  | 29. DATE OF INJURY (Month, Day, Year)<br>28a. DATE OF INJURY: 28b. TIME OF INJURY: M 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  |
| 29. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 30. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 31. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  | 32. SIGNATURE AND TITLE OF CERTIFIER<br>Michael Fadden MD   |  |  |  |
| 33. LICENSE NUMBER<br>D26388   |  |  |  | 34. DATE SIGNED (Month, Day, Year)<br>1-31-96   |  |  |  |
| 35. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Michael Fadden MD 302 Collins Harlock Md 21643  |  |  |  |   |  |  |  |
| 36. DATE FILED (Month, Day, Year)<br>FEB 05 1996   |  |  |  | 37. REGISTRAR'S SIGNATURE<br>John D. Randall  |  |  |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04753

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Tamble Emerson Hamilton

2. Date of Death

Month

Day

Year

2

7

96

3. Time of Death

0009

4a. Facility Name (If not institution, give street and number)

University of Maryland Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral  
Director

5. Social Security Number

404 - 20 - 1049

8. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

69

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Mn.

8. Date of Birth

(Month, Day, Year)

April 21, 1926

9. Birthplace (State or Foreign Country)

Kentucky

Usual Residence of Decedent

10e. State

Maryland

10b. County

Cecil

10c. City, Town or Location

North East

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

412 Old Elk Neck Road

10f. Zip Code

21901

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16e. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Security Department

16b. Kind of Business/Industry

Chemical  
Manufacturer

17. Father's Name (First, Middle, Last)

Lee Hamilton

18. Mother's Name (First, Middle, Maiden Surname)

Betty Akers

19e. Informant's Name/Relationship (Type, Print)

Edna M. Hamilton

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

412 Old Elk Neck Road, North East, MD 21901

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Hart's Cemetery

Date

Feb. 10

1996

20c. Location - City or Town, State

Elk Neck, Maryland

21. Signature of Funeral Service Licensee

Robert T. Crouch

22. Name and Address of Facility

Crouch Funeral Home  
127 South Main Street, North East, MD 21901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Sepsis

Due to (or as a consequence of):

b. Granulocytopenia

Due to (or as a consequence of):

c. Chemotherapy

Due to (or as a consequence of):

d. AMI

Approximate  
Interval Between  
Onset and Death

19 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ARDS

High Output Cardiac Failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michael Gallagher MD

29c. License number

P-7745

29d. Date signed (Month, Day, Year)

2-7-96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Michael Gallagher 22 S. Green St., Dept of Medicine, Balt, MD 21201

31. Date filed (Month, Day, Year)

FEB 09 1996

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR   |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 96 04754  |  |
|--|--|--|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)   |  |  |  | 2. DATE OF DEATH   |  |  |  | 3. TIME OF DEATH  |  |
| Pearl M. Hash  |  |  |  | Feb. 11 1996   |  |  |  | 11:00 AM  |  |
| 4. SOCIAL SECURITY NUMBER  |  | 5. SEX   |  | 6. AGE (In yrs. last birthday)   |  | 7. DATE OF BIRTH   |  | 8. BIRTHPLACE (State or Foreign Country)  |  |
| 218-32-8259  |  | 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                 |  | 81 YRS.  |  | Mar 7 1914   |  | North Carolina  |  |
| 9a. FACILITY NAME (If not institution, give street and number)   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH  |  |  |  | 9c. COUNTY OF DEATH   |  |
| Calvert Manor Healthcare Center  |  |  |  | Rising Sun   |  |  |  | Cecil   |  |
| 10a. STATE   |  |  |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION                                  |  | 10d. INSIDE CITY LIMITS?  |  |
| MD   |  |  |  | Cecil  |  | Rising Sun   |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER   |  |  |  | 10f. ZIP CODE  |  | 10g. CITIZEN OF WHAT COUNTRY?                                |  |   |  |
| 1881 Telegraph Rd.   |  |  |  | 21911  |  | USA  |  |   |  |
| 11. MARITAL STATUS   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN?   |  | 14. RACE — American Indian, Black, White, etc.               |  |   |  |
| 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>Specify:                        |  | Specify:<br>White  |  |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) |  | 16b. KIND OF BUSINESS/INDUSTRY                               |  |   |  |
| Elementary/Secondary (0-12) 5 College (1-4 or 5+) 5  |  |  |  | Seamstress   |  | Clothing Manufacturer  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)  |  |  |  |   |  |
| John Jones   |  |  |  | Sarah Curd   |  |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)              |  |  |  |   |  |
| Wanda Gross  |  |  |  | 25 Clark Rd. Perryville MD 21903   |  |  |  |   |  |
| 20a. METHOD OF DISPOSITION   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)                      |  | DATE   |  | 20c. LOCATION — City or Town, State                          |  |   |  |
| 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | Brookview Cemetery Feb 14 1996   |  | Rising Sun MD  |  |  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  |  |  |  | 22. NAME AND ADDRESS OF FACILITY   |  |  |  |   |  |
| Richard L. Joslin  |  |  |  | R. T. Foard Funeral Home, P.A.<br>111 S. Queen St. Rising Sun MD 21911                                     |  |  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |  |  |  |  | Approximate Interval Between Onset and Death  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  |  |  |  |  |  |  | 4 days  |  |
| a. Congestive Heart Failure  |  |  |  |  |  |  |  | 3x5   |  |
| b. D.S.C.V.D.  |  |  |  |  |  |  |  |   |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |  |  |   |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |  |  |   |  |
| 24. WAS AN AUTOPSY PERFORMED?  |  |  |  |  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?   |  |
| 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |  |  |  |  | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?   |  |  |  |  |  |  |  | 26. PLACE OF DEATH (Check only one)   |  |
| 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |  |  |  |  | HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |
| 27. MANNER OF DEATH  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY  |  | 28c. INJURY AT WORK?   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
| 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide |  |  |  | M  |  | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |   |  |
|  |  | 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)               |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                               |  |  |  |   |  |
|  |  |  |  |  |  |  |  |   |  |
| 29a. CERTIFIER (Check only one)  |  |  |  |  |  |  |  | 29c. LICENSE NUMBER   |  |
| 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |  |  | 0-11115   |  |
| 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |  |  |  | 29d. DATE SIGNED (Month, Day, Year)   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  |  |  |  |  |  |  |  | 29d. DATE SIGNED (Month, Day, Year)   |  |
| Neil R. Taylor MD  |  |  |  |  |  |  |  | 2-11-96   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  |  |  |  |  |  |  |  |   |  |
| Neil R. Taylor MD P.O. 459 Rising Sun, MD 21911  |  |  |  |  |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)  |  |  |  | 32. REGISTRAR'S SIGNATURE  |  |  |  |   |  |
| FEB 12 1996  |  |  |  | Julia Davidson-Randall   |  |  |  |   |  |



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04755

|  |   |  |  |  |  |  |  |  |
|--|---|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>WILLIAM FREDERICK HUTCHISON JR.</b>  |  |  |  | 2. Date of Death<br>Month Day Year<br><b>FEB. 08, 1996</b> |  | 3. Time of Death<br><b>0900AM</b>  |  |
|  | 4a. Facility Name (If not Institution, give street and number)<br><b>ROUTE #242</b> |  |  |  | 4b. City, Town, or Location of Death<br><b>BUSHWOOD</b>    |  | 4c. County of Death<br><b>ST. MARY'S</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>219-46-5172</b>                                     | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>48</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.                             | 8. Date of Birth (Month, Day, Year)<br><b>Jul 5, 1947</b>  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                    |  |
|  | Usual Residence of Decedent   |  |  |  |  |  |  |  |
| 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>St. Mary's</b>   |  | 10c. City, Town or Location<br><b>Coltons Point</b>  |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br><b>P. O. Box 7 Gerrard Drive</b>   |   |  |  | 10f. Zip Code<br><b>20626</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)  |   |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Shop Mechanic</b>  |  | 16b. Kind of Business/Industry<br><b>PEPCO</b>   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>William F. Hutchison, Sr.</b>  |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Sara Deritta Kidwell</b>   |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Patricia A. Hutchison-spouse</b>  |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P. O. Box 7 Gerrard Dr., Coltons Point, MD 20626</b>                                     |  |  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Huntt Crematory</b>   |  | Date<br><b>2-12</b>  |  | 20c. Location - City or Town, State<br><b>Waldorf, Maryland</b>  |  |  |
| 21. Signature of Funeral Service Licensee<br><b>Mark G. Brohawn M00053</b>   |   |  |  | 22. Name and Address of Facility<br><b>Huntt Funeral Home, Inc.<br/>P. O. Box 156, Waldorf, MD 20604-0156</b>  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>e. <b>Head and Neck Injuries</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |  |  |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |  |
|  |   |  |  |  |  | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |
|  |   |  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>ROADWAY</b> |  |  |  |  |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)<br><b>2-8-96</b>  |  | 28b. Time of Injury<br><b>454 A.M.</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |
|  |   | 28d. Describe how injury occurred<br><b>motor vehicle collision</b>  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>street</b>  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>Rt 242<br/>Milestown, St Mary's Co, Md</b>  |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   |  |  |  |  |  |  |  |
| 29b. Signature and title of certifier<br><b>Dennis J. Chute</b>  |   |  |  | 29c. License number<br><b>O.C.M.E</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>FEBRUARY 9, 1996</b>   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dennis J. Chute</b> <b>111 Penn Street, Baltimore, Maryland 21201</b>   |   |  |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 13 1996</b>  |   |  |  | 32. Registrar's Signature<br><b>Julia Davidson Randall</b>   |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 96 04756

Physician  
/Medical  
Examiner

Funeral  
Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>JOHN S HARRISON</b>  |  |   |  | 2. Date of Death<br>Month <b>February</b> Day <b>9</b> Year <b>1996</b>   |  | 3. Time of Death<br><b>1:35 p.m.</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>St. Mary's Hospital</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Leonardtwn</b>   |  | 4c. County of Death<br><b>St. Mary's</b>   |  |
| 5. Social Security Number<br><b>220-62-8419</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>41</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>April 29, 1954</b>   |  |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>St. Mary's</b>  |  | 10c. City, Town or Location<br><b>Mechanicville</b>   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>5340 New Market Turner Rd.</b>   |  |   |  | 10f. Zip Code<br><b>20659</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Maintenance Mechanic</b>  |  | 16b. Kind of Business/Industry<br><b>U.S. Government</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Thomas E. Harrison, Sr.</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Summa)<br><b>Elsie Mae McDonagh Harrison</b>   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Thomas E. Harrison, Sr.</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P.O. Box 1675 LaPlata, MD 20646</b>   |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Trinity Mem. Gardens</b>   |  | Data<br><b>2/12/96</b>  |  | 20c. Location - City or Town, State<br><b>Waldorf, MD</b>  |  |
| 21. Signature of Funeral Service Licensee<br><b>David C. Echols</b> MO0945  |  |   |  | 22. Name and Address of Facility<br><b>AREHART-ECHOLS FUNERAL HOME, INC.</b><br><b>P.O. Box 567 LaPlata, MD 20646</b>   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Suicide</b><br>Due to (or as a consequence of):<br>b. <b>GSW Head</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |   |  |  |  |
| Approximate Interval Between Onset and Death<br><b>Unk</b><br><b>LL</b>   |  |   |  |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Cornie Back Pain</b><br><b>Depression</b>  |  |   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)<br><b>N/A</b>  |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>N/A</b>  |  |   |  | 28d. Describe how injury occurred<br><b>N/A</b>   |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>N/A</b>  |  |   |  |   |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.<br><input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |   |  |  |  |
| 29b. Signature and title of certifier<br><b>Dr. J. J. J. J.</b>   |  |   |  | 29c. License number<br><b>D12285</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>2-9-96</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)  |  |   |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 12 1996</b>   |  | 32. Registrar's Signature<br><b>Julia Jackson-Randall</b>   |  |   |  |  |  |



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04757

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

AMELIA

C

HUNGERFORD

2. Date of Death  
Month Day Year  
FEBRUARY 8, 19963. Time of Death  
6:15 AM

4e. Facility Name (If not institution, give street and number)

South River Nursing &amp; Rehab Center

4b. City, Town, or Location of Death

EDGEWATER

4c. County of Death

ANNE ARUNDEL

Funeral  
Director

5. Social Security Number

212-74-8306

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 20 1900

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10e. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Edgewater

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3810 Contee Wharf Road

10f. Zip Code

21037

10g. Citizen of What Country?

Anne Arundel

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16e. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Martin BILLOW BILON

18. Mother's Name (First, Middle, Maiden Surname)

Cecelia Martin

19e. Informant's Name/Relationship (Type, Print)

CLYDE HUNGERFORD/SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3810 Contee Wharf Road Edgewater, Maryland 21037

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

ARLINGTON NATIONAL CEMETERY

Date

2/13/96

20c. Location - City or Town, State

ARLINGTON, VIRGINIA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

JOHN M. TAYLOR FUNERAL HOME, INC.  
147 DUKE OF GLOUCESTER ST. ANNAPOLIS, MD 2140123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. MULTI-INFARCT DEMENTIA

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

5 YEARS

b. ATHEROSCLEROSIS

Due to (or as a consequence of):

Sequently list conditions,  
if any, leading to immediate  
cause. Enter underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. ---

Due to (or as a consequence of):

d. ---

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CORONARY HEART DISEASE (SUSPECTED)

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending  
investigation6 ☐ Could not be  
determined28e. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury et  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)

29b. Signature and title of certifier

29c. License number

DO 5928

29d. Date signed (Month, Day, Year)

FEBRUARY 8, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

CHARLES W. KINZER, M.D. 2003 MEDICAL PKWY #100 ANNAPOLIS, MD 21401

31. Date filed (Month, Day, Year)

FEB 09 1996

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04758

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LORETTA S. HIGGINS

2. Date of Death  
Month Day Year  
February 1, 19963. Time of Death  
7:30 P.M.

4a. Facility Name (If not institution, give street and number)

5 Sunnydale Way

4b. City, Town, or Location of Death

Reisterstown

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

216-52-9348

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

48

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Apr 5, 1947

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Reisterstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5 Sunnydale Way

10f. Zip Code

21136

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4 years

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Vice President

16b. Kind of Business/Industry

Hemlock Landscaping

17. Father's Name (First, Middle, Last)

Ernest L. Schaefer

18. Mother's Name (First, Middle, Maiden Surname)

Marie R. Hartley

19a. Informant's Name/Relationship (Type, Print)

Peter W. Higgins (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5 Sunnydale Way Reisterstown, MD 21136

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

St. Charles Cemetery

Date

2-6-96

20c. Location - City or Town, State

Pikesville, Maryland

21. Signature of Funeral Service Licensee

John K. Arnold 2

22. Name and Address of Facility

Loring Byers Funeral Directors, Inc.

8728 Liberty Rd. Randallstown, MD 21133

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Brain Metastasis

4 years

Due to (or as a consequence of):

b. Metastatic Breast Carcinoma

4 years

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Bone Marrow and Hepatic Metastasis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Marvin J. Feldman MD

Attending

29c. License number

D07930

29d. Date signed (Month, Day, Year)

February 2, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

MARVIN J. FELDMAN

301 St. Paul Place

Baltimore, Md. 21202

31. Date filed (Month, Day, Year)

FEB -5 1996

32. Registrar's Signature

John A. Russell

State  
Registrar

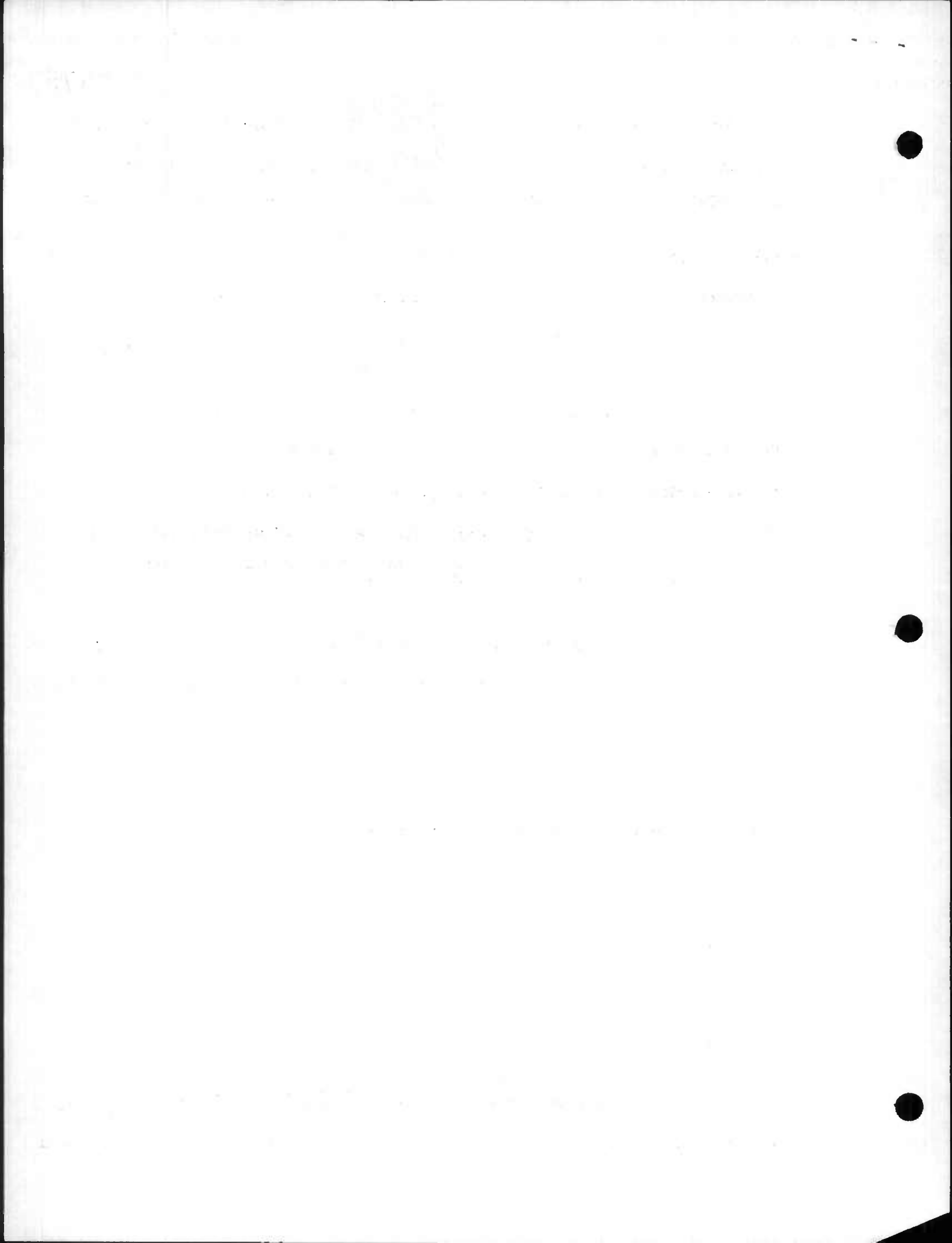
Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04759

|   |   |   |  |  |   |  |  |   |   |  |
|---|---|---|--|--|---|--|--|---|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Roy Eugene Henderson                              |   |  |  | 2. Date of Death<br>Month January Day 28, 1996 Year |  | 3. Time of Death<br>3:15 pm                          |   |   |  |
|   | 4e. Facility Name (If not Institution, give street and number)<br>Frederick Memorial Hospital |   |  |  | 4b. City, Town, or Location of Death<br>Frederick   |  | 4c. County of Death<br>Frederick                     |   |   |  |
| Funeral<br>Director   | 5. Social Security Number<br>217-34-1673  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br>58 Yrs.           |  | 8. Date of Birth (Month, Day, Year)<br>April 5, 1937 |   |   |  |
|   | 9. Birthplace (State or Foreign Country)<br>Virginia  |   | 10a. State<br>Maryland   |  | 10b. County<br>Frederick                            |  | 10c. City, Town or Location<br>Ijamsville            |   |   |  |
| Usual Residence of Decedent   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br>3499 Adgate Drive  |   | 10f. Zip Code<br>21754   |  | 10g. Citizen of What Country?<br>U.S.A.   |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |   |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Laboratory Technician  |  | 16b. Kind of Business/Industry<br>Food & Drug Administration   |   |  |  |   |   |  |
| 17. Father's Name (First, Middle, Last)<br>Roy E. Henderson   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Louise Cash   |   |  |  |   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>H. Ruth Henderson - Wife  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3499 Adgate Drive, Ijamsville, Maryland 21754   |   |  |  |   |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Resthaven Memorial Gardens 1/31   |  | 20c. Location - City or Town, State<br>Frederick, Maryland   |   |  |  |   |   |  |
| 21. Signature of Funeral Service Licensee<br><i>Roy L. Williams</i>   |   |   |  | 22. Name and Address of Facility<br>Olin L. Molesworth, P.A., Funeral Home<br>26401 Ridge Road, Damascus, Maryland 20872-0117  |   |  |  |   |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <i>Acute Myeloid Leukemia with Complications</i><br>Due to (or as a consequence of):<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |   |   |  |  |   |  |  |   | Approximate Interval Between Onset and Death<br>36 months |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Peritonitis 2 years</i>  |   |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |   |  |
|   |   |   |  |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |  |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28d. Describe how Injury occurred   |   |  |
|   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   |   |  |  |   |  |  |   |   |  |
| 29b. Signature and title of certifier<br><i>W. L. Henderson</i>   |   |   |  | 29c. License number<br>D-18191   |   | 29d. Date signed (Month, Day, Year)<br>1-29-76   |  |   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Arthur G. Morrow, M.D. 187 Thomas John St. Frederick, MD 21702  |   |   |  |  |   |  |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br>FEB 02 1996  |   | 32. Registrar's Signature<br><i>John Davidson-Randall</i>   |  |  |   |  |  |   |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

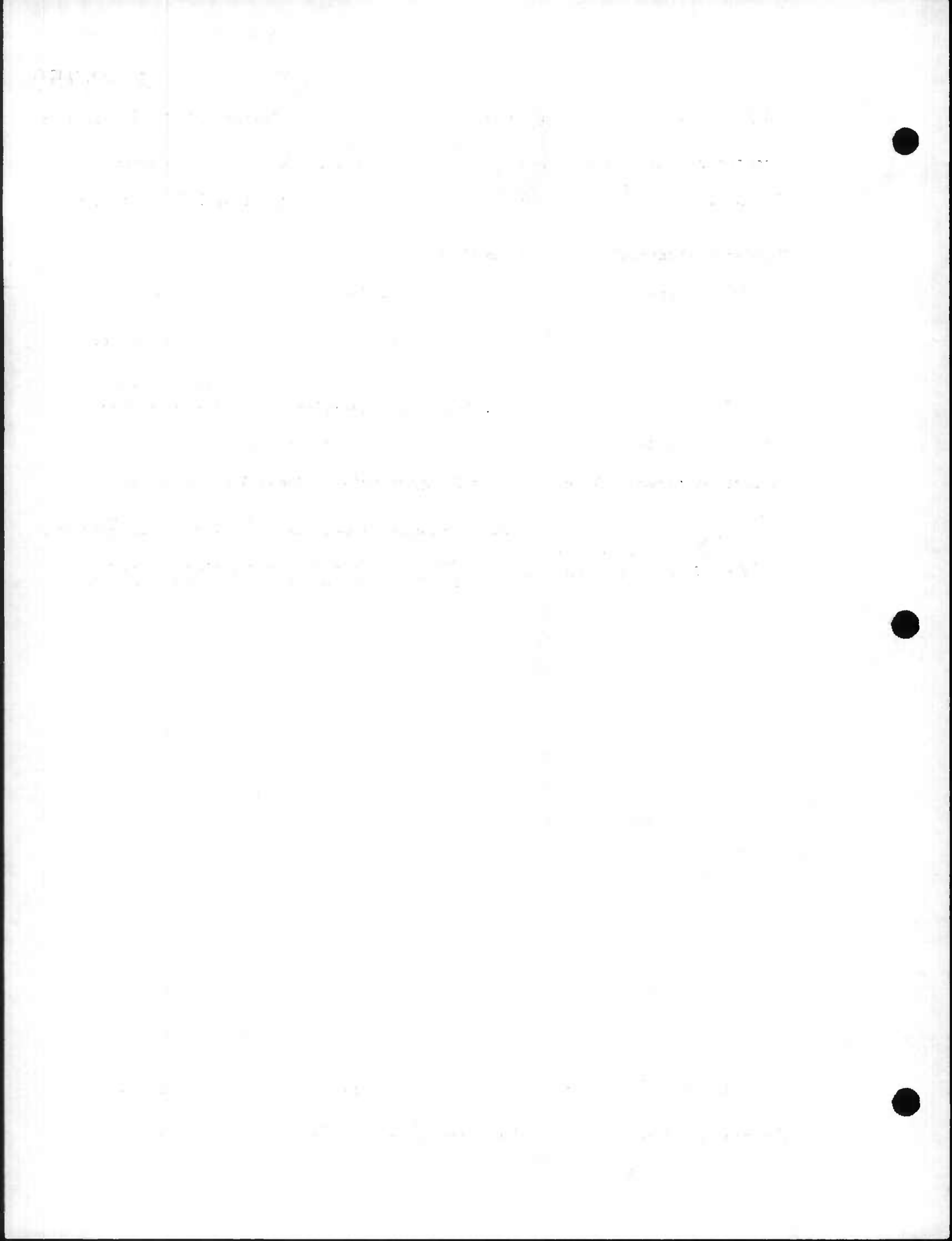
Division of Vital Records, P.O. Box 68760,

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Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1 - FOR STATE REGISTRAR  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH |  |   |  | REG. NO.   |  |
|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Bettina Adele HAGAN</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 25, 1996</b>   |  | 3. TIME OF DEATH<br>HOUR MIN.<br><b>7:10 am</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>214-10-2707</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F          |  | 6. AGE (In yrs. last birthday)<br><b>81</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>May 27, 1914</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>  |  |   |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Homewood Retirement Center</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Frederick</b>  |  |
| 9c. COUNTY OF DEATH<br><b>Frederick</b>  |  |   |  | 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Frederick</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Frederick</b>  |  |   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>31 West Patrick Street</b>  |  |
| 10f. ZIP CODE<br><b>21701</b>  |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+) <b>2</b>  |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Own Home</b>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Howard E COLLIFLOWER</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>M Helen COLLIFLOWER</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mr. James David Hagan (Son)</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>26 High Street, Sharon, Massachusetts 02067</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Mount Olivet Cemetery Jan 29, 1996 Frederick, Maryland</b>  |  | 20c. LOCATION — City or Town, State  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Kathleen Roberson</i> <b>M00706</b>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Keeney &amp; Basford P.A. Funeral Home<br/>106 East Church St, Frederick, MD 21701</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>pneumonia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><b>① Atherosclerotic Heart Disease<br/>② Fracture of Femur</b><br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |  |  |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide  |  |   |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>12/30/1995</b>   |  | 28b. TIME OF INJURY<br><b>1 pm</b>   |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  | 28d. DESCRIBE HOW INJURY OCCURRED<br><b>Patient moved in bed</b>  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>At home</b>   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>31 W Patrick St, Frederick, MD</b>  |  |   |  | 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>S. Robert R. Roberts MD DO9867</b> |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>S. Robert R. Roberts MD</i>  |  |   |  | 29c. LICENSE NUMBER<br><b>D16428</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>January 26, 1996</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Casper E. Cline, III, M.D., 300 West Ninth Street, Frederick, Maryland 21701</b>   |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>JAN 26 1996</b>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>Davidson-Rodell</i>   |  |  |  |

ARMY 20

ARMY 20

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |   |  |  |                                       |  | REG. NO.   |  |  |  |
|--|--|--|--|--|---|--|--|---------------------------------------|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Sister Marian Heffernan</b>   |  |  |  |  |   | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Jan. 23, 1996</b>   |  | 3. TIME OF DEATH<br><b>9:27 A. M.</b> |  |  |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>173-38-3552</b>  |  | 5. SEX<br><b>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F</b>  | 6. AGE (In yrs. last birthday)<br><b>81</b> YRS. | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Oct. 7, 1914</b>   | 8. BIRTHPLACE (State or Foreign Country)<br><b>Pennsylvania</b> |  |  |                                       |  |  |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Villa St. Michael</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Emmitsburg</b>   |   | 9c. COUNTY OF DEATH<br><b>Frederick</b>  |  |                                       |  |  |  |  |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Frederick</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Emmitsburg</b>   |   | 10d. INSIDE CITY LIMITS?<br><b>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO</b> |  |                                       |  |  |  |  |  |
| 10e. STREET AND NUMBER<br><b>333 South Seton Avenue</b>  |  |  |  | 10f. ZIP CODE<br><b>21727</b>  |   | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |                                       |  |  |  |  |  |
| 11. MARITAL STATUS<br><b>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married</b>  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</b><br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</b> Specify:   |   | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                                 |  |                                       |  |  |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) <input checked="" type="checkbox"/> College (1-4 or 5+)</b><br><b>Secondary 4</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Nursing Assistant</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Religious Community Daughters of Charity</b>  |   |  |  |                                       |  |  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Patrick Francis Heffernan</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mary Rosalie Agnew</b>   |   |  |  |                                       |  |  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Sister Camilla Harant</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>333 S. Seton Ave., Emmitsburg, MD 21727</b>  |   |  |  |                                       |  |  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><b>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State</b><br><b>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>ST. JOSEPH'S CEMETERY 1/25/96</b>  |  | 20c. LOCATION — City or Town, State<br><b>EMMITSBURG, MD. 21727</b>  |   |  |  |                                       |  |  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>John M. Skiles</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>SKILES FUNERAL HOME<br/>210 W. MAIN ST., EMMITSBURG, MD. 21727</b>  |   |  |  |                                       |  |  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b><br><b>a. Cerebrovascular Accident</b><br><b>b. Atherosclerotic Vascular Disease</b><br><b>c. Rheumatic Heart Disease</b><br><b>d. Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST</b> |  |  |  |  |   |  |  |                                       |  | Approximate Interval Between Onset and Death<br><b>72 hrs</b><br><b>710 yrs</b>                                  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Rheumatic Heart Disease</b>   |  |  |  |  |   |  |  |                                       |  | 24a. WAS AN AUTOPSY PERFORMED?<br><b>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</b> |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO</b> |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</b>   |  | 26. PLACE OF DEATH (Check only one)<br><b>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</b><br><b>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</b> |  | 27. MANNER OF DEATH<br><b>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</b><br><b>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined</b> |   | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>       |  | 28c. INJURY AT WORK?<br><b>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO</b>                      |  | 28d. DESCRIBE HOW INJURY OCCURED   |  |
| 29a. CERTIFIER (Check only one)<br><b>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b><br><b>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Alan Carroll M.D.</b>  |  | 29c. LICENSE NUMBER<br><b>D18705</b>   |   | 29d. DATE SIGNED (Month, Day, Year)<br><b>JANUARY 23, 1996</b>   |  |                                       |  |  |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>ALAN CARROLL M.D., 310 S. SETON AVE., EMMITSBURG, MD. 21727</b>  |  |  |  |  |   |  |  |                                       |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>JAN 29 1996</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>  |   |  |  |                                       |  |  |  |  |  |



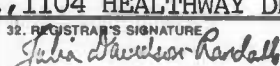
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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |   |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>NORA HOOVER INSLEY</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Jan. 30 1996</b>   |  | 3. TIME OF DEATH<br><b>2:25 A<sup>M</sup></b>   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>214-10-8013</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>97</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>July 15, 1898</b>                                     |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Pennsylvania</b>   |  |  |  |   |  |   |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Salisbury Nursing &amp; Rehab Center</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Salisbury, Md.</b>  |  | 9c. COUNTY OF DEATH<br><b>WICOMICO</b>  |   |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Wicomico</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Salisbury</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><b>300 Lemmon Hill</b>  |  |  |  | 10f. ZIP CODE<br><b>21801</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                      |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6</b><br>College (1-4 or 5+) <b>0</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Poultry Grower</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Poultry</b>  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Cyrus P Hoover</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Emma Heisey</b>   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>D. Jean Adkins</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>11 Fenwick Acres, Fenwick Island, DE 19944</b>  |  |   |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Wicomico Memorial Park</b>   |  | DATE<br><b>2/1</b>  |  | 20c. LOCATION — City or Town, State<br><b>Salisbury, MD</b>                                     |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Holloway Funeral Home</b><br><b>501 Snow Hill Rd., Salisbury, MD 21801</b>   |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Advanced Senile Dementia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |   | Approximate Interval Between Onset and Death<br><b>years</b>  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>History Rectal Cancer</b><br><b>Angina, Severe DTD</b><br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>  |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |   |  |   |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> 1 <input type="checkbox"/> YES <input type="checkbox"/> NO  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                |   |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |   |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |   |   |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>  |  |  |  | 29c. LICENSE NUMBER<br><b>D-39813</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>1/30/96</b>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>MICHAEL ATKINS, M.D., 1104 HEALTHWAY DR., SALISBURY, MD. 21804</b>  |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 01 1996</b>   |  | 32. REGISTRAR'S SIGNATURE<br>   |  |   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

as of 1965

1/1/65

1/1/65

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 96 04763

|   |  |   |   |   |  |  |  |   |  |
|---|--|---|---|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Esther P. Joines   |   |   |   | 2. Date of Death<br>Month Day Year<br>February 12, 1996  |  | 3. Time of Death<br>10:05 AM                                     |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>40 Deer Trail Lane   |   |   |   | 4b. City, Town, or Location of Death<br>Conowingo  |  | 4c. County of Death<br>Cecil                                     |   |  |
| Funeral<br>Director   | 5. Social Security Number<br>161-20-1649   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>71 Yrs.   | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>May 7, 1924   |  | 9. Birthplace (State or Foreign Country)<br>West Virginia |  |
|   | Usual Residence of Decedent  |   |   |   |  |  |  |   |  |
| To Be Completed by Funeral Director   | 10a. State<br>Maryland   | 10b. County<br>Cecil  | 10c. City, Town or Location<br>Conowingo  |   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |
|   | 10e. Street and Number<br>40 Deer Trail Lane   |   |   | 10f. Zip Code<br>21918  |  | 10g. Citizen of What Country?<br>USA   |  |   |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White |   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 Collega (1-4or 5+) 12  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Laborer                      |  | 16b. Kind of Business/Industry<br>Food Processing  |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br>Charles K. Turner   |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Ella J. Kennison  |  |  |   |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br>Glenn C. McClure Son   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>40 Deer Trail Lane, Conowingo, Md. 21918 |  |  |  |   |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Stewartstown Cemetery   |   | Data<br>2/15/96  |  | 20c. Location - City or Town, State<br>Stewartstown, Pa.         |   |  |
|   | 21. Signature of Funeral Service Licensee<br><i>J.J. Hartenstein</i>   |   |   | 22. Name and Address of Facility<br>J.J. Hartenstein Mortuary, Inc.<br>19 S. Main St., Stewartstown, Pa. 17363-0325                       |  |  |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. ALZHEIMER'S DISEASE<br>Due to (or as a consequence of):<br><br>b.<br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |   |  |  |  |   |  |
|   | Approximate Interval Between Onset and Death<br>7 YEARS  |   |   |   |  |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>ALZHEIMER'S DISEASE<br>HYPOTHYROIDISM.  |  |   |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |   |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |  |  |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how Injury occurred                         |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><i>S. Dhanjani M.D.</i>  |   |   |  |  |  |   |  |
| 29c. License number<br>D45344   |  | 29d. Date signed (Month, Day, Year)<br>2-12-96  |   |   |  |  |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>S. Dhanjani, M.D. P.O. Box 781, Perryville, Md. 21903   |  |   |   |   |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br>FEB 21 1996  |  | 32. Registrar's Signature<br><i>John W. ...</i>   |   |   |  |  |  |   |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Adm #1, 2 5-96-WASHCO-Certificate of Death, KB

Reg. No.

96

04764

|   |  |  |   |                                 |  |
|---|--|--|---|---------------------------------|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>JOHN DAVID JACKSON, JR.  |  | 2. Date of Death<br>Month FEBRUARY Day 01 Year 1996   |                                 | 3. Time of Death<br>18:09PM  |
|   | 4a. Facility Name (If not institution, give street and number)<br>WASHINGTON COUNTY HOSPITAL   |  | 4b. City, Town, or Location of Death<br>HAGERSTOWN  |                                 | 4c. County of Death<br>WASHINGTON  |
| Funeral<br>Director                           | 5. Social Security Number<br>218-21-0836   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>7 Yrs.  | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   |
|   | 8. Date of Birth (Month, Day, Year)<br>Nov. 6, 1988  |  | 9. Birthplace (State or Foreign Country)<br>Maryland  |                                 |  |
| To Be Completed by Funeral Director           | Usual Residence of Decedent  |  |   |                                 |  |
|   | 10a. State<br>Maryland   | 10b. County<br>Washington  | 10c. City, Town or Location<br>Hagerstown   |                                 | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |
|   | 10e. Street and Number<br>156 W. North Avenue  |  | 10f. Zip Code<br>21740  |                                 | 10g. Citizen of What Country?<br>USA   |
|   | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |                                 | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:         |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 1<br>College (1-4or 5+) 1   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>student  |                                 | 16b. Kind of Business/Industry<br>school   |
|   | 17. Father's Name (First, Middle, Last)<br>John David Jackson, Jr.   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Wiyette S. Hunter  |                                 |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Gladys A. McGee  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>156 W. North Avenue Hagerstown, Maryland 21740   |                                 |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Rose Hill Cemetery  |                                 | 20c. Location - City or Town, State<br>2/7 Hagerstown, Maryland  |
|   | 21. Signature of Funeral Service Licensee<br><i>Gerald N. Minnich</i>  |  | 22. Name and Address of Facility<br>Gerald N. Minnich 305 N. Potomac Street<br>Funeral Home Hagerstown, Maryland  |                                 |  |
|   | 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |                                 |  |
| Physician<br>/Medical<br>Examiner             | Immediate Cause (Final disease or condition resulting in death)<br>a. <i>ASD AND NECK INJURY</i><br>Due to (or as a consequence of):   |  |   |                                 | Approximate Interval Between Onset and Death   |
|   | Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d.  |  |   |                                 |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |                                 | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
|   |  |  |   |                                 | 24a. Was an autopsy performed?<br><i>Inspection</i><br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |
|   |  |  |   |                                 | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |
|   |  |  |   |                                 |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 28. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                 |  |
|   | 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day Year)<br>2 1 96   | 28b. Time of Injury<br>1730 P M | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |
|   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><i>ROADWAY</i>   |  | 28d. Describe how injury occurred<br><i>TRANSPORTATION SUBJECT ON CYCLES STRUCK BY</i>  |                                 |  |
|   | 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><i>600 BUCK PROSPECT HAGERSTOWN WASH DC</i>   |                                 |  |
|   | 29b. Signature and title of certifier<br><i>Margie Anne Yell</i>   |  | 29c. License number<br>O.C.M.E.   |                                 | 29d. Date signed (Month, Day, Year)<br>FEBRUARY 02, 1996   |
| State Registrar                               | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>Margarita Korell M.D. 111 Penn Street, Baltimore, Maryland 21201   |  |   |                                 |  |
|   | 31. Date filed (Month, Day, Year)<br>FEB 5 1996  |  | 32. Registrar's Signature<br><i>Johi...</i>   |                                 |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Herbert Leon Jones   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>Feb. 3 96   |  | 3. TIME OF DEATH<br>12:00 p.m.  |  |
| 4. SOCIAL SECURITY NUMBER<br>213-24-2050   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>68 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>Aug. 31, 1927   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>22132 Havercamp Road   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Preston  |  | 9c. COUNTY OF DEATH<br>Caroline   |  |
| RESIDENCE OF DECEDENT  |  |   |  |   |  |   |  |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Caroline   |  | 10c. CITY, TOWN OR LOCATION<br>Preston  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>22132 Havercamp Road   |  |   |  | 10f. ZIP CODE<br>21655  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: Black                                    |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 7th<br>College (1-4 or 5+)   |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Machine Operator   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Maryland Plastics Inc.  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Samuel Edward Jones   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Anna Rosetta Green   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Ruth T. Jones  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>22132 Havercamp Rd. Preston, Md. 21655   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Mt. Pleasant U. M. Church 12/10/96   |  | 20c. LOCATION — City or Town, State<br>Preston, Md.   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>John A. Prince</i>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>Bennie Smith Funeral Home<br>P.O. Box 1687, Easton, Maryland 21601  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Small Cell Lung Cancer ± Liver Metastases/Failure</i><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <i>Smoking</i><br>c.<br>d.<br>Approximate Interval Between Onset and Death 2yrs<br>4yrs |  |   |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>① Chronic Obstructive Pulmonary Disease</i><br><i>② Peptic Ulcer Dz</i> <i>③ Osteoarthritis</i>   |  |   |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28c. DESCRIBE HOW INJURY OCCURRED   |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Jeffrey T. Denton MD</i>   |  |   |  | 29c. LICENSE NUMBER<br>D47492   |  | 29d. DATE SIGNED (Month, Day, Year)<br>2/7/96   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>Jeffrey T. Denton MD</i> 332 N Main St Federal's Linc, MD  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>FEB 07 1996   |  | 32. REGISTRAR'S SIGNATURE<br><i>John A. Prince</i>  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2000-00

2000-00



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

96 04766

REG. NO.

|  |  |  |  |   |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Mary Madeline Jones  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>February 7 1996   |  |  |  | 3. TIME OF DEATH<br>5:05 A M  |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br>213-60-4472   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>44 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>March 14, 1951                                     |  | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Residence: 40 Old Schoolhouse Drive  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Port Deposit   |  |  |  | 9c. COUNTY OF DEATH<br>Cecil  |  |  |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |  |  |   |  |  |  |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Cecil   |  | 10c. CITY, TOWN OR LOCATION<br>Port Deposit   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO       |  |  |  |
| 10e. STREET AND NUMBER<br>40 Old Schoolhouse Drive   |  |  |  | 10f. ZIP CODE<br>21904  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |   |  |  |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: Black                             |  |   |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) Twelve Years<br>College (1-4 or 5+) -----  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Housekeeping Services  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Bainbridge Naval Training Center<br>Port Deposit, Maryland |  |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Robert Henry Jones, Sr.   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Addie E. Griffin   |  |  |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Addie E. Griffin Jones   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>40 Old Schoolhouse Drive, Port Deposit, Maryland 21904   |  |  |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Mt. Zoar Cemetery 2/10/96   |  | 20c. LOCATION — City or Town, State<br>Conowingo, Maryland  |  |  |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Thomas M. Patterson, Sr.</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Lee A. Patterson & Son Funeral Home<br>Perryville, Maryland 21903   |  |  |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>MYOCARDIAL INFARCTION</i><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  |  |  | Approximate Interval Between Onset and Death  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>- HTN - Depression - ANEMIA</i>   |  |  |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  |   |  |  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY M   |  | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO            |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>T. Patterson</i>   |  |  |  | 29c. LICENSE NUMBER<br><i>D42800</i>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>2/8/96</i>   |  |   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Thomas A. Biondo, M.D., 319 South Union Avenue, Havre de Grace, Maryland 21078  |  |  |  |   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>FEB 09 1996   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson Randall</i>  |  |  |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2025 19

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 96 04767

Physician  
/Medical  
Examiner

Funeral  
Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Tyler Chance Johnson</b>  |  |   |  | 2. Date of Death<br>Month <b>February</b> Day <b>10</b> Year <b>96</b>   |  | 3. Time of Death<br><b>16:35</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Harford Memorial Hospital</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Harford</b>   |  | 4c. County of Death<br><b>Harford</b>  |  |
| 5. Social Security Number<br><b>Unknown</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Feb 10 1996</b>  |  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Cecil</b>   |  | 10c. City, Town or Location<br><b>Port Deposit</b>   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>17 O'leary Lane</b>   |  |   |  | 10f. Zip Code<br><b>21904</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>0</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Never worked</b>  |  | 16b. Kind of Business/Industry<br><b>Never worked</b>  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Richard E. Johnson, Jr.</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Robin R. Carroll</b>   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Richard E. Johnson, Jr.</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>17 O'leary Lane Port Deposit MD 21904</b>  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Bethel Cemetery 2-17-1996</b>  |  | 20c. Location - City or Town, State<br><b>Chesapeake City MD</b>   |  |  |  |
| 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>R. T. Foard Funeral Home, P.A.<br/>111 S. Queen St. Rising Sun MD 21911</b>   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Reversible</b><br>Due to (or as a consequence of):<br><br>b.<br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |  |  | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|  |  |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|  |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|  |  | 28d. Describe how injury occurred   |  |  |  | 28e. Place of Injury - At home, farm, street, tectory, office building, etc. (Specify)   |  |
|  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |  |  |  |  |
| 29b. Signature and title of certifier<br>  |  |   |  | 29c. License number<br><b>47502</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>2/10/96</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Arthur V. Morey, MD Harford Memorial Hospital</b>   |  |   |  |  |  |  |  |
| 31. Date filed (Month, Day Year)<br><b>FEB 12 1996</b>   |  |   |  | 32. Registrar's Signature<br>  |  |  |  |

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04768

|   |   |   |  |  |  |  |  |  |
|---|---|---|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>ALMA JOHNSON</b>                                 |   |  |  | 2. Date of Death<br>Month <b>02</b> Day <b>04</b> Year <b>1996</b> |  | 3. Time of Death<br><b>3-00 AM</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>NORTH ARUNDEL HOSPITAL</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>GLEN BURNIE</b>         |  | 4c. County of Death<br><b>ANNE ARUNDEL</b>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>447-09-0587</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>75</b> Yrs.   | If Under 1 Year<br>Months Days                                     | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Oct. 25 1920</b>                                     | 9. Birthplace (State or Foreign Country)<br><b>Oklahoma</b>  |
|   | Usual Residence of Decedent   |   |  |  |  |  |  |  |
| 10a. State<br><b>MD</b>   |   | 10b. County<br><b>Anne Arundel</b>  |  | 10c. City, Town or Location<br><b>Severna Park</b>   |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br><b>17 Saint Ives Drive</b>  |   |   |  | 10f. Zip Code<br><b>21146</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>5+</b> College (1-4or 5+) <b>5+</b>   |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Teacher</b>  |  | 16b. Kind of Business/Industry<br><b>Education</b>   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Malcolm McCain</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Audrey Tiller</b>  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Russell B. Johnson</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>17 Saint Ives Dr. Severna Park, MD 21146</b>   |  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Arlington Natl. Cem.</b>   |  | Date<br><b>2/9</b>   |  | 20c. Location - City or Town, State<br><b>Arlington, Va.</b>   |  |  |
| 21. Signature of Funeral Service Licensee<br>   |   |   |  | 22. Name and Address of Facility<br><b>Barranco &amp; Sons Funeral Home<br/>495 Ritchie Hwy. Severna Park, MD. 21146</b>   |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. PNEUMONIA</b><br>Due to (or as a consequence of):<br><b>b. METASTATIC LUNG CANCER</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b> |   |   |  |  |  |  |  | Approximate Interval Between Onset and Death<br><b>10 DAYS</b><br><br><b>1 YEAR</b>  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |  |
|   |   |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred  |
|   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   |   |  |  |  |  |  |  |
| 29b. Signature and title of certifier<br>   |   | 29c. License number<br><b>D46962</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>02-04-1996</b>   |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>M. SHIRAZI, MD. HOUSE PHYSICIAN, NORTH ARUNDEL HOSPITAL, MD 21061.</b>   |   |   |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 09 1996</b>   |   | 32. Registrar's Signature<br>   |  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04769

|   |  |  |  |  |  |   |  |  |   |   |  |   |  |   |  |
|---|--|--|--|--|--|---|--|--|---|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Nellie N. Johnson   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>February 6, 1996   |  |   |  | 3. TIME OF DEATH<br>7:15 p. M  |   |   |  |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br>220-12-2456  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>86 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  | IF UNDER 24 HRS.<br>HOURS MIN.   |   | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>June 21, 1909   |  | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Edw.W.McCready Memorial Hospital  |  |  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Crisfield  |  |  |   | 9c. COUNTY OF DEATH<br>Somerset   |  |   |  |   |  |
| RESIDENCE OF DECEDENT   |  |  |  |  |  |   |  |  |   |   |  |   |  |   |  |
| 10a. STATE<br>Maryland  |  |  | 10b. COUNTY<br>Somerset  |  |  | 10c. CITY, TOWN OR LOCATION<br>Marion Station   |  |  |   | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |   |  |   |  |
| 10e. STREET AND NUMBER<br>6327 Charles Cannon Road  |  |  |  |  |  | 10f. ZIP CODE<br>21838  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.       |   |  |   |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |  |   | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                                    |  |   |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>Grade 6 — — —  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Seamstress  |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Clothing   |   |   |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Elmer Nelson   |  |  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Nola Riffin  |  |  |   |   |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Bonnie Johnson (Daughter)   |  |  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>6327 Charles Cannon Rd.- Marion Station, MD 21838  |  |  |   |   |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>St. Paul's Cemetery 2/9/96  |  |   |  | 20c. LOCATION — City or Town, State<br>Marion Station, MD                            |   |   |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Robert H. Bradshaw, Jr.  |  |  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Bradshaw & Sons Funeral Home<br>306 W. Main St.- Crisfield, MD 21817  |  |  |   |   |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. Sepsis<br>b. Urinary Tract Infection<br>c.<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>e.<br>f.<br>g.<br>h.<br>i.<br>j.<br>k.<br>l.<br>m.<br>n.<br>o.<br>p.<br>q.<br>r.<br>s.<br>t.<br>u.<br>v.<br>w.<br>x.<br>y.<br>z.<br>aa.<br>ab.<br>ac.<br>ad.<br>ae.<br>af.<br>ag.<br>ah.<br>ai.<br>aj.<br>ak.<br>al.<br>am.<br>an.<br>ao.<br>ap.<br>aq.<br>ar.<br>as.<br>at.<br>au.<br>av.<br>aw.<br>ax.<br>ay.<br>az.<br>ba.<br>bb.<br>bc.<br>bd.<br>be.<br>bf.<br>bg.<br>bh.<br>bi.<br>bj.<br>bk.<br>bl.<br>bm.<br>bn.<br>bo.<br>bp.<br>bq.<br>br.<br>bs.<br>bt.<br>bu.<br>bv.<br>bw.<br>bx.<br>by.<br>bz.<br>ca.<br>cb.<br>cc.<br>cd.<br>ce.<br>cf.<br>cg.<br>ch.<br>ci.<br>cj.<br>ck.<br>cl.<br>cm.<br>cn.<br>co.<br>cp.<br>cq.<br>cr.<br>cs.<br>ct.<br>cu.<br>cv.<br>cw.<br>cx.<br>cy.<br>cz.<br>da.<br>db.<br>dc.<br>dd.<br>de.<br>df.<br>dg.<br>dh.<br>di.<br>dj.<br>dk.<br>dl.<br>dm.<br>dn.<br>do.<br>dp.<br>dq.<br>dr.<br>ds.<br>dt.<br>du.<br>dv.<br>dw.<br>dx.<br>dy.<br>dz.<br>ea.<br>eb.<br>ec.<br>ed.<br>ee.<br>ef.<br>eg.<br>eh.<br>ei.<br>ej.<br>ek.<br>el.<br>em.<br>en.<br>eo.<br>ep.<br>eq.<br>er.<br>es.<br>et.<br>eu.<br>ev.<br>ew.<br>ex.<br>ey.<br>ez.<br>fa.<br>fb.<br>fc.<br>fd.<br>fe.<br>ff.<br>fg.<br>fh.<br>fi.<br>fj.<br>fk.<br>fl.<br>fm.<br>fn.<br>fo.<br>fp.<br>fq.<br>fr.<br>fs.<br>ft.<br>fu.<br>fv.<br>fw.<br>fx.<br>fy.<br>fz.<br>ga.<br>gb.<br>gc.<br>gd.<br>ge.<br>gf.<br>gg.<br>gh.<br>gi.<br>gj.<br>gk.<br>gl.<br>gm.<br>gn.<br>go.<br>gp.<br>gq.<br>gr.<br>gs.<br>gt.<br>gu.<br>gv.<br>gw.<br>gx.<br>gy.<br>gz.<br>ha.<br>hb.<br>hc.<br>hd.<br>he.<br>hf.<br>hg.<br>hh.<br>hi.<br>hj.<br>hk.<br>hl.<br>hm.<br>hn.<br>ho.<br>hp.<br>hq.<br>hr.<br>hs.<br>ht.<br>hu.<br>hv.<br>hw.<br>hx.<br>hy.<br>hz.<br>ia.<br>ib.<br>ic.<br>id.<br>ie.<br>if.<br>ig.<br>ih.<br>ii.<br>ij.<br>ik.<br>il.<br>im.<br>in.<br>io.<br>ip.<br>iq.<br>ir.<br>is.<br>it.<br>iu.<br>iv.<br>iw.<br>ix.<br>iy.<br>iz.<br>ja.<br>jb.<br>jc.<br>jd.<br>je.<br>jf.<br>jg.<br>jh.<br>ji.<br>jj.<br>jk.<br>jl.<br>jm.<br>jn.<br>jo.<br>jp.<br>jq.<br>jr.<br>js.<br>jt.<br>ju.<br>jv.<br>jw.<br>jx.<br>jy.<br>jz.<br>ka.<br>kb.<br>kc.<br>kd.<br>ke.<br>kf.<br>kg.<br>kh.<br>ki.<br>kj.<br>kk.<br>kl.<br>km.<br>kn.<br>ko.<br>kp.<br>kq.<br>kr.<br>ks.<br>kt.<br>ku.<br>kv.<br>kw.<br>kx.<br>ky.<br>kz.<br>la.<br>lb.<br>lc.<br>ld.<br>le.<br>lf.<br>lg.<br>lh.<br>li.<br>lj.<br>lk.<br>ll.<br>lm.<br>ln.<br>lo.<br>lp.<br>lq.<br>lr.<br>ls.<br>lt.<br>lu.<br>lv.<br>lw.<br>lx.<br>ly.<br>lz.<br>ma.<br>mb.<br>mc.<br>md.<br>me.<br>mf.<br>mg.<br>mh.<br>mi.<br>mj.<br>mk.<br>ml.<br>mm.<br>mn.<br>mo.<br>mp.<br>mq.<br>mr.<br>ms.<br>mt.<br>mu.<br>mv.<br>mw.<br>mx.<br>my.<br>mz.<br>na.<br>nb.<br>nc.<br>nd.<br>ne.<br>nf.<br>ng.<br>nh.<br>ni.<br>nj.<br>nk.<br>nl.<br>nm.<br>no.<br>np.<br>nq.<br>nr.<br>ns.<br>nt.<br>nu.<br>nv.<br>nw.<br>nx.<br>ny.<br>nz.<br>oa.<br>ob.<br>oc.<br>od.<br>oe.<br>of.<br>og.<br>oh.<br>oi.<br>oj.<br>ok.<br>ol.<br>om.<br>on.<br>oo.<br>op.<br>oq.<br>or.<br>os.<br>ot.<br>ou.<br>ov.<br>ow.<br>ox.<br>oy.<br>oz.<br>pa.<br>pb.<br>pc.<br>pd.<br>pe.<br>pf.<br>pg.<br>ph.<br>pi.<br>pj.<br>pk.<br>pl.<br>pm.<br>pn.<br>po.<br>pp.<br>pq.<br>pr.<br>ps.<br>pt.<br>pu.<br>pv.<br>pw.<br>px.<br>py.<br>pz.<br>qa.<br>qb.<br>qc.<br>qd.<br>qe.<br>qf.<br>qg.<br>qh.<br>qi.<br>qj.<br>qk.<br>ql.<br>qm.<br>qn.<br>qo.<br>qp.<br>qq.<br>qr.<br>qs.<br>qt.<br>qu.<br>qv.<br>qw.<br>qx.<br>qy.<br>qz.<br>ra.<br>rb.<br>rc.<br>rd.<br>re.<br>rf.<br>rg.<br>rh.<br>ri.<br>rj.<br>rk.<br>rl.<br>rm.<br>rn.<br>ro.<br>rp.<br>rq.<br>rr.<br>rs.<br>rt.<br>ru.<br>rv.<br>rw.<br>rx.<br>ry.<br>rz.<br>sa.<br>sb.<br>sc.<br>sd.<br>se.<br>sf.<br>sg.<br>sh.<br>si.<br>sj.<br>sk.<br>sl.<br>sm.<br>sn.<br>so.<br>sp.<br>sq.<br>sr.<br>ss.<br>st.<br>su.<br>sv.<br>sw.<br>sx.<br>sy.<br>sz.<br>ta.<br>tb.<br>tc.<br>td.<br>te.<br>tf.<br>tg.<br>th.<br>ti.<br>tj.<br>tk.<br>tl.<br>tm.<br>tn.<br>to.<br>tp.<br>tq.<br>tr.<br>ts.<br>tu.<br>tv.<br>tw.<br>tx.<br>ty.<br>tz.<br>ua.<br>ub.<br>uc.<br>ud.<br>ue.<br>uf.<br>ug.<br>uh.<br>ui.<br>uj.<br>uk.<br>ul.<br>um.<br>un.<br>uo.<br>up.<br>uq.<br>ur.<br>us.<br>ut.<br>uu.<br>uv.<br>uw.<br>ux.<br>uy.<br>uz.<br>va.<br>vb.<br>vc.<br>vd.<br>ve.<br>vf.<br>vg.<br>vh.<br>vi.<br>vj.<br>vk.<br>vl.<br>vm.<br>vn.<br>vo.<br>vp.<br>vq.<br>vr.<br>vs.<br>vt.<br>vu.<br>vv.<br>vw.<br>vx.<br>vy.<br>vz.<br>wa.<br>wb.<br>wc.<br>wd.<br>we.<br>wf.<br>wg.<br>wh.<br>wi.<br>wj.<br>wk.<br>wl.<br>wm.<br>wn.<br>wo.<br>wp.<br>wq.<br>wr.<br>ws.<br>wt.<br>wu.<br>wv.<br>ww.<br>wx.<br>wy.<br>wz.<br>xa.<br>xb.<br>xc.<br>xd.<br>xe.<br>xf.<br>xg.<br>xh.<br>xi.<br>xj.<br>xk.<br>xl.<br>xm.<br>xn.<br>xo.<br>xp.<br>xq.<br>xr.<br>xs.<br>xt.<br>xu.<br>xv.<br>xw.<br>xx.<br>xy.<br>xz.<br>ya.<br>yb.<br>yc.<br>yd.<br>ye.<br>yf.<br>yg.<br>yh.<br>yi.<br>yj.<br>yk.<br>yl.<br>ym.<br>yn.<br>yo.<br>yp.<br>yq.<br>yr.<br>ys.<br>yt.<br>yu.<br>yv.<br>yw.<br>yx.<br>yy.<br>yz.<br>za.<br>zb.<br>zc.<br>zd.<br>ze.<br>zf.<br>zg.<br>zh.<br>zi.<br>zj.<br>zk.<br>zl.<br>zm.<br>zn.<br>zo.<br>zp.<br>zq.<br>zr.<br>zs.<br>zt.<br>zu.<br>zv.<br>zw.<br>zx.<br>zy.<br>zz. |  |  |  |  |  |   |  |  |   |   |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Alzheimer's Dementia  |  |  |  |  |  |   |  |  |   |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  |  |  |   |  |  |   |   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |   |   |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  |  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |   |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |  |   |  |  |   |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>James A. Sterling, MD  |  |  |  |  |  | 29c. LICENSE NUMBER<br>D10814   |  |  | 29d. DATE SIGNED (Month, Day, Year)<br>2/6/96 |   |  |   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Dr. James A. Sterling, Main St., Crisfield, Md. 21817  |  |  |  |  |  |   |  |  |   |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>FEB 09 1996  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall  |  |   |  |  |   |   |  |   |  |   |  |

20740 20

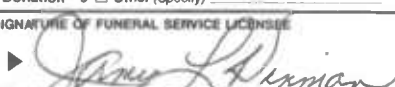


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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR  |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 96 04770   |  |   |  |  |  |
|--|--|--|--|---|--|--|--|--|--|---|--|--|--|
| CERTIFICATE OF DEATH   |  |  |  | REG. NO.  |  |  |  |  |  |   |  |  |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br>HARRY HENRY JONES  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>FEBRUARY 7, 1996  |  |  |  | 3. TIME OF DEATH<br>0040 A   |  |   |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br>002-16-9536   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>73 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>June 12, 1922 |  | 8. BIRTHPLACE (State or Foreign Country)<br>IOWA |  |
| 9a. FACILITY NAME (If not Institution, give street and number)<br>PENINSULA REGIONAL MEDICAL CENTER  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>SALISBURY  |  |  |  | 9c. COUNTY OF DEATH<br>WICOMICO  |  |   |  |  |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |  |  |  |  |   |  |  |  |
| 10a. STATE<br>MARYLAND   |  | 10b. COUNTY<br>SOMERSET  |  | 10c. CITY, TOWN OR LOCATION<br>MANOKIN  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |   |  |  |  |
| 10e. STREET AND NUMBER<br>29123 POND RUN ROAD  |  |  |  | 10f. ZIP CODE<br>21836  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.  |  |   |  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: WHITE   |  |   |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 7 College (1-4 or 5+)  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>PAINTER  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>AUTO INDUSTRY  |  |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>HARRY HENRY JONES, SR.  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>RACHEL NEWMAN  |  |  |  |  |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>MARGARET T. JONES  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>29123 POND RUN ROAD, MANOKIN, MD. 21836  |  |  |  |  |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>SALISBURY CREMATORY   |  | DATE<br>2/7   |  | 20c. LOCATION — City or Town, State<br>SALISBURY, MARYLAND                           |  |  |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSE<br> M00294   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>HINMAN FUNERAL HOME<br>11673 SOMERSET AVE., PRINCESS ANNE, MD. 21853  |  |  |  |  |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>Respiratory Arrest + Apystole<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Severe End Stage Dilated Ischemic Cardiomyopathy<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Severe End Stage Inoperable Coronary Artery Disease<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |  |  | Approximate Interval Between Onset and Death<br>minutes   |  |  |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying causes given in Part I.  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |   |  |  |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>  |  |  |  |   |  |  |  |  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |  |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br> MS  |  |  |  | 29c. LICENSE NUMBER<br>044069   |  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br>2-7-96  |  |   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>S. L. ANDREWS, MD 106 MILFORD ST #104 SALISBURY MD 21807  |  |  |  |   |  |  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>FEB 09 1996   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>  |  |  |  |  |  |   |  |  |  |

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1 FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04771

|   |  |  |  |  |  |   |  |  |  |   |  |   |  |   |  |
|---|--|--|--|--|--|---|--|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Dora E. Keithley  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>Feb 7 1996   |  |   |  | 3. TIME OF DEATH<br>8:40pm M   |  |   |  |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br>219-14-0165  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>84 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS.<br>HOURS MIN.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>Dec 2 1911  |  | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Calvert Manor Healthcare Center   |  |  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Rising Sun   |  |  |  | 9c. COUNTY OF DEATH<br>Cecil  |  |   |  |   |  |
| 10a. STATE<br>MD  |  |  |  | 10b. COUNTY<br>Cecil   |  | 10c. CITY, TOWN OR LOCATION<br>Colora   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |   |  |   |  |
| 10e. STREET AND NUMBER<br>2494 Liberty Grove Rd   |  |  |  |  |  | 10f. ZIP CODE<br>21917  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  |   |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                                 |  |   |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 7 College (1-4 or 5+)   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Seamstress  |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Clothing Manufacturing                             |  |   |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Edison Burkins   |  |  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Marietta Curry   |  |  |  |   |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Patricia L. Durham  |  |  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1844 Pulaski Hwy Havre de Grace MD 21078   |  |  |  |   |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>W Nottingham Cmtery Feb 10 1996   |  |   |  | 20c. LOCATION — City or Town, State<br>Colora MD                                     |  |   |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>R. T. Foard Funeral Home, P.A.<br>111 S. Queen St. Rising Sun MD 21911  |  |  |  |   |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>CONGESTIVE HEART FAILURE</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely flat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. <u>ARTERIOSCLEROTIC HEART DISEASE</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. _____<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. _____ |  |  |  |  |  |   |  |  |  |   |  | Approximate Interval Between Onset and Death<br>3 YEARS   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>RENAL CARCINOMA, CHRONIC RENAL FAILURE</u><br><u>DEMENTIA</u><br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  |  |  |   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |   |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide   |  |  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |   |  |
|   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)         |  |   |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |  |   |  |  |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  |  |  |  |  | 29c. LICENSE NUMBER<br>D45344   |  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br>2-8-96   |  |   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Suresh M. Dhanjani M.D. P.O. Box 781, Perryville, Md. 21903  |  |  |  |  |  |   |  |  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>FEB 08 1996  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>  |  |   |  |  |  |   |  |   |  |   |  |

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 96 04772

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |  |   |  |   |  |  |  |   |  |  |  |
|---|--|---|--|---|--|--|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>JOSEPH C. KLEIN</b>  |  |   |  | 2. Date of Death<br>Month <b>FEBRUARY</b> Day <b>6</b> Year <b>1996</b>   |  |  |  | 3. Time of Death<br><b>9:55 PM</b>  |  |  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Meridian Nursing Home</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Severna Park</b>   |  |  |  | 4c. County of Death<br><b>A.A.</b>  |  |  |  |
| 5. Social Security Number<br><b>104-09-0957</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>83</b> Yrs.  |  | If Under 1 Year<br>Months Days   |  | If Under 24 Hrs.<br>Hours Min.  |  | 8. Date of Birth (Month, Day, Year)<br><b>4-13-1912</b>  |  |
| 9. Birthplace (State or Foreign Country)<br><b>PA</b>   |  |   |  |   |  |  |  |   |  |  |  |
| Usual Residence of Decedent   |  |   |  |   |  |  |  |   |  |  |  |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>WILCOMICO</b>   |  | 10c. City, Town or Location<br><b>SAUSBURY</b>  |  |  |  |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>1401 Emerson Avenue</b>  |  |   |  | 10f. Zip Code<br><b>21801</b>   |  |  |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>                     |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>1+</b>  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Sales person</b>  |  |  |  | 16b. Kind of Business/Industry<br><b>SPICE Co.</b>  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>JOSEPH ADOLPH KLEIN</b>   |  |   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MINNIE KUHLE</b>   |  |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>ART KLEIN</b>  |  |   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>491 Eastwood Court, Severna Park, MD 21146</b> |  |   |  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory</b>  |  | Date<br><b>2-8-96</b>  |  | 20c. Location - City or Town, State<br><b>Catonsville, MD</b>                               |  |  |  |
| 21. Signature of Funeral Service Licensee<br>   |  |   |  |   |  | 22. Name and Address of Facility<br><b>BARRANCO FH Severna Park, MD</b>  |  |   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>UROSEPSIS</b><br>Due to (or as a consequence of):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>Due to (or as a consequence of):</b><br><br><b>PARKINSON'S DISEASE</b><br><b>DEMENTIA</b><br><b>ATRIAL FIBRILLATION</b> |  |   |  |   |  |  |  |   |  | Approximate Interval Between Onset and Death<br><b>10 DAYS</b>   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>PARKINSON'S DISEASE</b><br><b>DEMENTIA</b><br><b>ATRIAL FIBRILLATION</b>   |  |   |  |   |  |  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |   |  |  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  |   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |   |  |  |  |   |  |  |  |
| 29b. Signature and title of certifier<br>Attending  |  |   |  |   |  | 29c. License number<br><b>D 21776</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>2/7/96</b>  |  |  |  |
| 30. Name and address of person who completed cause of death (item 23a) (Type, Print)<br><b>SURYA P. MUMFRA MD 203 E. PATAYSCA AV. BALTIMORE MD 21225</b>  |  |   |  |   |  |  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 09 1996</b>   |  |   |  | 32. Registrar's Signature<br>   |  |  |  |   |  |  |  |

State Registrar

STT:

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1 - FOR STATE REGISTRAR   |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO. 96 04773   |   |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>William Thomas KABRICK, JR.</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>January</b> , DAY <b>20</b> , YEAR <b>1996</b>   |  | 3. TIME OF DEATH<br><b>7:00 AM</b>  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>217-07-5075</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br><b>87</b> YRS. | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>  | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b> | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Nov. 13, 1908</b>                                  |   |
| 8. FACILITY NAME (If not institution, give street and number)<br><b>Frederick Memorial Hospital</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Frederick</b>   |  | 9c. COUNTY OF DEATH<br><b>Frederick</b>   |   |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |   |   |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Frederick</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Frederick</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><b>609 Himes Avenue, Unit 103</b>   |  |  |  | 10f. ZIP CODE<br><b>21703</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                         |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>  |  | 15a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Blaster/Driller</b>  |  | 15b. KIND OF BUSINESS/INDUSTRY<br><b>Cement Company</b>   |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William Thomas KABRICK, SR.</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Ella May FISHER</b>   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mrs. Emily Louise Kabrick</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>609 Himes Ave., Unit 103, Frederick, Md. 21703</b>  |  |   |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Resthaven Memorial Gardens, Jan. 23, 1996 Frederick, Maryland</b>  |  | 20c. LOCATION — City or Town, State   |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Richard E. Hoop</b> M00255  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Keeney and Basford P.A. Funeral Home<br/>106 East Church St., Frederick, Md. 21701</b>   |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Uremia</b><br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>a. <b>Multiple Myeloma</b><br>b.<br>c.<br>d.<br><br>DUE TO (OR AS A CONSEQUENCE OF):<br>DUE TO (OR AS A CONSEQUENCE OF):<br>DUE TO (OR AS A CONSEQUENCE OF):<br>DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  |   | Approximate Interval Between Onset and Death<br><b>1 Month</b><br><br><b>1 Year</b>   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                |   |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |   |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |   |   |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Austin Pearre, Jr.</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D 09689</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>Jan. 20, 1996</b>                                     |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Dr. A. Austin Pearre, Jr., MD 300 West Ninth Street, Frederick, Maryland 21701</b>  |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>JAN 22 1996</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>John Davidson Randall</b>   |  |   |   |

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04774

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Rex Eugene Kelley

2. Date of Death

February 5 1996

3. Time of Death

11:15p.m.

Funeral  
Director

4a. Facility Name (If not Institution, give street and number)

7990 Terry Drive

4b. City, Town, or Location of Death

Port Tobacco

4c. County of Death

Charles

5. Social Security Number

004-20-9330

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

69

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

April 15, 1926

9. Birthplace (State or Foreign Country)

Maine

Usual Residence of Decedent

10a. State

MD

10b. County

Charles

10c. City, Town or Location

Port Tobacco

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7990 Terry Dr.

10f. Zip Code

20677

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Pepco

16b. Kind of Business/Industry

Electricity Product.

17. Father's Name (First, Middle, Last)

Forest J. Kelley

18. Mother's Name (First, Middle, Maiden Surname)

Opal Pierce Kelley

19a. Informant's Name/Relationship (Type, Print)

Elizabeth Kelley

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. box 343 Port Tobacco, MD 20677

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory, or other place)

St. Ignatius Church Cem. 2/8/96 Chapel Pt., MD

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

David C. Echols MO0945

22. Name and Address of Facility

AREHART-ECHOLS FUNERAL HOME, INC.  
P.O. Box 567 LaPlata, MD 20646

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Cancer Scrotum

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Krishan Mathur, M.D.

29c. License number

D28352

29d. Date signed (Month, Day, Year)

February 6, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Krishan Mathur, M.D. P.O. Box 2729, La Plata, MD 20646

31. Date filed (Month, Day, Year)

FEB 07 1996

32. Registrar's Signature

John Davidson Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner





1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04775

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Doris Frederica Kershner</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Jan. 22, 1996</b>   |  | 3. TIME OF DEATH<br><b>7:30 A. M.</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>161-42-9529</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>75</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Feb. 10, 1920</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>New Jersey</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>4740 Burkittsville Rd.</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Knoxville</b>  |  |
| 9c. COUNTY OF DEATH<br><b>Frederick</b>   |  |  |  | 10a. STATE<br><b>Md.</b>   |  | 10b. COUNTY<br><b>Frederick</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Knoxville</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>4740 Burkittsville Rd.</b>  |  |
| 10f. ZIP CODE<br><b>21758</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b></b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>homemaker</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>own home</b>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William L. Barber</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Marie Elizabeth Boyd</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Dr. John W. Kershner</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4740 Burkittsville Rd., Knoxville, Md. 21758</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Hillside Cemetery 1/26 Philadelphia, Pa.</b>   |  | 20c. LOCATION — City or Town, State  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Donald B. Thompson Funeral Home<br/>31 E. Main St., Middletown, Md. 21769</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Intra cerebral Hemorrhage</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br><br>Approximate interval Between Onset and Death<br><b>10 minutes</b> |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Degenerative Arthritis, Hypercholesterolemia, Labile Hypertension</b><br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Mary P. Howell M.D.</b>  |  |  |  |
| 29c. LICENSE NUMBER<br><b>D46075</b>  |  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>1/24/96</b>  |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>915 Fall house Ave Suite 203 Frederick MD 21769</b>   |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>JAN 29 1996</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

25 1975

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

10

| 1 - FOR STATE REGISTRAR   |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 96 04776  |  |                                |  |   |  |
|---|--|--|--|---|--|---|--|---|--|--------------------------------|--|---|--|
| CERTIFICATE OF DEATH  |  |  |  | REG. NO.  |  |   |  |   |  |                                |  |   |  |
| 1. DECEASED'S NAME (First, Middle, Last)<br>ELIZABETH V. KOEHLER  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>FEB. 2, 1996  |  |   |  | 3. TIME OF DEATH<br>0815 M  |  |                                |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br>217-12-8347  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>72 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>7-27-23   |  | 8. BIRTHPLACE (State or Foreign Country)<br>MD.   |  |                                |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>56 GRANDPORT  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BERLIN   |  |   |  | 9c. COUNTY OF DEATH<br>WORCESTER  |  |                                |  |   |  |
| RESIDENCE OF DECEASED   |  |  |  |   |  |   |  |   |  |                                |  |   |  |
| 10a. STATE<br>MD.   |  | 10b. COUNTY<br>WORCESTER   |  | 10c. CITY, TOWN OR LOCATION<br>BERLIN   |  |   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO       |  |                                |  |   |  |
| 10e. STREET AND NUMBER<br>56 GRANDPORT  |  |  |  | 10f. ZIP CODE<br>21811  |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  |                                |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: WHITE  |  |                                |  |   |  |
| 15. DECEASED'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+)  |  | 16a. DECEASED'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>BUS DRIVER  |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>BOARD OF EDUCATION  |  |   |  |                                |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>WILLIAM NICHOLSON  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>ISABELLE BROOKS  |  |   |  |   |  |                                |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>LYNN N. HARDESTY  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2241 OCEAN PINES BERLIN, MD., 21811  |  |   |  |   |  |                                |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>BROOKVILLE CEMETERY 2-7   |  | 20c. LOCATION — City or Town, State<br>BROOKVILLE, MD.  |  |   |  |   |  |                                |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>ULLRICH FUNERAL HOME BERLIN, MD., 2   |  |   |  |   |  |                                |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. lung CANCER<br>Due TO (OR AS A CONSEQUENCE OF):<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. Due TO (OR AS A CONSEQUENCE OF):<br>c. Due TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |   |  | Approximate interval Between Onset and Death<br>2 years   |  |                                |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |                                |  |   |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |   |  |   |  |   |  |                                |  |   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  |   |  |   |  |   |  |                                |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |  | 28a. DATE OF INJURY (Month, Day, Year)<br>28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                      |  |                                |  |   |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                              |  |                                |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  | 29c. LICENSE NUMBER<br>D477676 |  | 29d. DATE SIGNED (Month, Day, Year)<br>2/2/96 |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>BSHER TOULEIMAT 9733 HEALTHWAY DR., BERLIN, MD. 21811  |  |  |  |   |  |   |  |   |  |                                |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>FEB 06 1996  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |   |  |   |  |                                |  |   |  |

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR  |  |   |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 96 04777   |  |                                     |  |
|---|--|---|--|---|--|--|--|--|--|-------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)  |  |   |  | 2. DATE OF DEATH  |  |  |  | 3. TIME OF DEATH   |  |                                     |  |
| WESLEY P. LEWIS   |  |   |  | FEBRUARY 7 1996   |  |  |  | 2:12 A M   |  |                                     |  |
| 4. SOCIAL SECURITY NUMBER   |  | 5. SEX  |  | 6. AGE (In yrs. last birthday)  |  | IF UNDER 1 YEAR                                |  | IF UNDER 24 HRS.   |  | 7. DATE OF BIRTH                    |  |
| 215-38-9771   |  | 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 67 YRS.   |  | MONTHS DAYS                                    |  | HOURS MIN.   |  | MAY 10 1928                         |  |
| 9a. FACILITY NAME (If not institution, give street and number)  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH   |  |  |  | 9c. COUNTY OF DEATH  |  |                                     |  |
| HARBOR HOSPITAL CENTER  |  |   |  | BALTIMORE   |  |  |  | BALTIMORE  |  |                                     |  |
| RESIDENCE OF DECEDENT   |  |   |  | 10c. CITY, TOWN OR LOCATION   |  |  |  | 10d. INSIDE CITY LIMITS?   |  |                                     |  |
| 10a. STATE  |  | 10b. COUNTY   |  | Fishing Creek   |  |  |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO      |  |                                     |  |
| Maryland  |  | Dorchester  |  |   |  |  |  |  |  |                                     |  |
| 10e. STREET AND NUMBER  |  |   |  | 10f. ZIP CODE   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?  |  |                                     |  |
| 2160 Hoopersville Road  |  |   |  | 21634   |  |  |  | U.S.A.   |  |                                     |  |
| 11. MARITAL STATUS  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN?  |  | 14. RACE — American Indian, Black, White, etc. |  |  |  |                                     |  |
| 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>1950-1971 |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>Specify:   |  | Specify:<br>White                              |  |  |  |                                     |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)   |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |                                     |  |
| Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2  |  |   |  | Food Service Managmnt   |  |  |  | Government   |  |                                     |  |
| 17. FATHER'S NAME (First, Middle, Last)   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)   |  |  |  |  |  |                                     |  |
| Willie O. Lewis   |  |   |  | Lola Hooper   |  |  |  |  |  |                                     |  |
| 19a. INFORMANT'S NAME (Type/Print)  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)   |  |  |  |  |  |                                     |  |
| Mrs. Lillian N. Lewis   |  |   |  | 2160 Hoopersville Rd., Fishing Creek, MD. 21634   |  |  |  |  |  |                                     |  |
| 20a. METHOD OF DISPOSITION  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)                                   |  | DATE  |  | 20c. LOCATION — City or Town, State            |  |  |  |                                     |  |
| 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | MDVeteransCemofEastShr2-9   |  |   |  | Hurlock, MD.                                   |  |  |  |                                     |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE   |  |   |  | 22. NAME AND ADDRESS OF FACILITY  |  |  |  |  |  |                                     |  |
| Roger R. Bromwell   |  |   |  | Curran-Bromwell Funeral Home, P.A.<br>308 High St., Cambridge, MD. 21613  |  |  |  |  |  |                                     |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |  |   |  |  |  | Approximate Interval Between Onset and Death                                 |  |                                     |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Respiratory Distress Syndrome  |  |   |  |   |  |  |  | 2 days   |  |                                     |  |
| Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  |  |   |  |   |  |  |  |  |  |                                     |  |
| b. Ca Upper lobe, Right Lung  |  |   |  |   |  |  |  | 6 mos.   |  |                                     |  |
| c. MODERATE OBSTRUCTIVE LUNG DISEASE  |  |   |  |   |  |  |  | 6 mos.   |  |                                     |  |
| d. Septic Syndrome  |  |   |  |   |  |  |  | 6 mos.   |  |                                     |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?   |  |                                     |  |
| Right Pneumonectomy   |  |   |  |   |  |  |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO      |  |                                     |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |   |  |   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  |  |                                     |  |
|   |  |   |  |   |  |  |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO      |  |                                     |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?  |  |   |  | 26. PLACE OF DEATH (Check only one)   |  |  |  |  |  |                                     |  |
| 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |   |  | HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |                                     |  |
| 27. MANNER OF DEATH   |  |   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY                            |  | 28c. INJURY AT WORK?   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
| 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  |   |  |   |  | M  |  | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                 |  |                                     |  |
|   |  |   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |  |                                     |  |
|   |  |   |  |   |  |  |  |  |  |                                     |  |
| 29a. CERTIFIER (Check only one)   |  |   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER   |  |  |  | 29c. LICENSE NUMBER  |  | 29d. DATE SIGNED (Month, Day, Year) |  |
| 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  | L. R. Arguillano Md   |  |  |  | D28988   |  | 2/7/96                              |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)   |  |   |  | 31. DATE FILED (Month, Day, Year)   |  |  |  | 32. REGISTRAR'S SIGNATURE  |  |                                     |  |
| Lino R. Arguillano Md 3001 South Hanover St. Balt. Md 21230   |  |   |  | FEB 09 1996   |  |  |  | Julia A. [Signature]   |  |                                     |  |

100 100



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR   |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 96 04778   |  |   |  |
|--|--|--|--|---|--|--|--|--|--|---|--|
| CERTIFICATE OF DEATH   |  |  |  | REG. NO.  |  |  |  |  |  |   |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>DAVID S. LILLY DAVID S. LILLY</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>FEB</b> DAY <b>8</b> YEAR <b>1996</b>  |  |  |  | 3. TIME OF DEATH<br><b>10:20 AM</b>                                |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>051-14-8743</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>75</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>July 5, 1920</b>  |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Washington D.C.</b> |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Howard County General Hospital</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Columbia</b>  |  |  |  | 9c. COUNTY OF DEATH<br><b>Howard</b>                               |  |   |  |
| 10a. STATE<br><b>Delaware</b>  |  |  |  | 10b. COUNTY<br><b>Sussex</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Rehoboth Beach</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>187 Snow Mass Run S. Aspen Meadows</b>  |  |  |  | 10f. ZIP CODE<br><b>19971</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                     |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |  |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>8</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Building Superintendent</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Chemical Company</b>   |  |  |  |  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Joseph Lilly</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Clara T. Maschauer</b>  |  |  |  |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>David Jones</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>10209 Tuscany Road, Ellicott City, MD 21042</b>   |  |  |  |  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>St. Peters Cemetery</b>  |  | DATE<br><b>02/10/1996</b>   |  | 20c. LOCATION — City or Town, State<br><b>Lewes, Delaware</b>  |  |  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Kenneth P. Dickens</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Parsell Atkins &amp; Lodge Funeral Home</b><br><b>1449 Kings Highway, Lewes, DE 19958</b>  |  |  |  |  |  |   |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>a. <b>ACUTE RESPIRATORY FAILURE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>b. <b>CONGESTIVE HEART FAILURE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>c. <b>ARTEROSCLEROTIC CARDIOVASCULAR DISEASE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>d.<br><br>Approximate Interval Between Onset and Death<br><b>2 WEEKS</b><br><b>4 WEEKS</b><br><b>1 YEAR</b> |  |  |  |   |  |  |  |  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>PERIPHERAL VASCULAR DISEASE</b><br><b>GANGRENE RIGHT FOOT</b><br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/></b>   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |  |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |  |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURED                                   |  |   |  |
|  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>TD</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D 36974</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>2/8/96</b>   |  |  |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>DAVID O. NYANSON MD</b>  |  |  |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>5999 HARPER'S FARM RD -200 E</b><br><b>COLUMBIA MD 21044</b>                                      |  |  |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 23 1996</b>  |  | 32. REGISTRAR'S SIGNATURE<br><b>John A. Hudson-Randall</b>   |  |   |  |  |  |  |  |   |  |

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |  |   |  |
|---|--|--|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Marie Elizabeth Lutman  |  |  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>2/6/86   |  | 3. TIME OF DEATH<br>0800 M  |  |
| 4. SOCIAL SECURITY NUMBER<br>102-18-9474  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>81 YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>Nov. 22, 1914   |  | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>509 Ridge Avenue  |  |  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Hagerstown  |  | 9c. COUNTY OF DEATH<br>Washington   |  |
| RESIDENCE OF DECEDENT   |  |  |  |  |  |  |  |   |  |
| 10a. STATE<br>Maryland  |  | 10b. COUNTY<br>Washington  |  | 10c. CITY, TOWN OR LOCATION<br>Hagerstown  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>509 Ridge Avenue  |  |  |  | 10f. ZIP CODE<br>21740   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8 College (1-4 or 5+)  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>waitress   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>hotel  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Jessie N. Spigler  |  |  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Ruby Viola Mays   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Lloyd S. Spigler  |  |  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>509 Ridge Avenue Hagerstown, Maryland 21740 |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Rose Hill Cemetery  |  | 20c. LOCATION — City or Town, State<br>2/12 Hagerstown, Maryland   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Gerald N. Minnich</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Gerald N. Minnich 305 N. Potomac Street<br>Funeral Home Hagerstown, Maryland   |  |  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Arteriosclerotic cardiovascular disease</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |  |  |  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Malnutrition</i><br><i>Dehydration</i>   |  |  |  |  |  |  |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>   |  |  |  |  |  | 29c. LICENSE NUMBER<br>D26806  |  | 29d. DATE SIGNED (Month, Day, Year)<br>2/8/86   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>Alvin D. H. 747 Northern Ave Hagerstown MD 21742</i>  |  |  |  |  |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>FEB 13 1986  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |  |  |   |  |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

2115-27

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04780

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

MARY KATHERINE LOCK

2. Date of Death

Month Day Year  
FEBRUARY 9 1996

3. Time of Death

12:20 AM

4a. Facility Name (If not Institution, give street and number)

SINAI HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE

5. Social Security Number

216-12-4761

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Mar. 22, 1918

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State  
Maryland10b. County  
Charles10c. City, Town or Location  
La Plata

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6499 Aura Drive

10f. Zip Code

20646

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No -

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Albert Lee Wood, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Clara Knopp

19a. Informant's Name/Relationship (Type, Print)

Mitchell W. Lock- Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7707 Heritage Farm Dr., Gaithersburg, MD 20879

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland Veterans' Cem.

Date

2-13

20c. Location - City or Town, State

Cheltenham, MD

21. Signature of Funeral Service Licensee

Mark G. Brohawn M00053

22. Name and Address of Facility

Huntt Funeral Home, Inc.

P. O. Box 156, Waldorf, MD 20604-0156

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC CANCER

Due to (or as a consequence of):

b. GASTRIC ADENOCARCINOMA

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

~20 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CECAL POLYPOIDS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

DAVID CHAN

29c. License number

AS4147357DC95

29d. Date signed (Month, Day, Year)

February 9, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

DAVID CHAN, SINAI HOSPITAL, BALTIMORE, MARYLAND

31. Date filed (Month, Day, Year)

FEB 13 1996

32. Registrar's Signature

John Davidson Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1941

1. The first part of the report deals with the general situation of the country and the progress of the work during the year.

2. The second part of the report deals with the results of the work during the year.

3. The third part of the report deals with the conclusions of the work during the year.

4. The fourth part of the report deals with the recommendations of the work during the year.

5. The fifth part of the report deals with the summary of the work during the year.

6. The sixth part of the report deals with the conclusions of the work during the year.

7. The seventh part of the report deals with the recommendations of the work during the year.

8. The eighth part of the report deals with the summary of the work during the year.

9. The ninth part of the report deals with the conclusions of the work during the year.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR  |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 96 04781  |  |  |  |   |  |
|--|--|--|--|---|--|---|--|---|--|--|--|---|--|
| CERTIFICATE OF DEATH   |  |  |  | REG. NO.  |  |   |  |   |  |  |  |   |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>JEAN LOVETT</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JANUARY 25, 1996</b>   |  |   |  | 3. TIME OF DEATH<br><b>11:40 AM</b>   |  |  |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>171-10-2522</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 8. AGE (in yrs. last birthday)<br><b>93</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  | IF UNDER 24 HRS.<br>HOURS MIN.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>AUG. 27, 1902</b>                |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>NORTH CAROLINA</b> |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>ATLANTIC GENERAL HOSPITAL</b>   |  |  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BERLIN, MARYLAND</b>  |  |   |  | 9c. COUNTY OF DEATH<br><b>WORCESTER</b>                                    |  |   |  |
| 10a. STATE<br><b>PA</b>  |  | 10b. COUNTY<br><b>DELAWARE</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>MEDIA</b>   |  |   |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |  |  |   |  |
| 10e. STREET AND NUMBER<br><b>16 LEVIS AVENUE (MIDDLETOWN TOWNSHIP)</b>   |  |  |  |   |  | 10f. ZIP CODE<br><b>19063</b>   |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  |   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b> |  |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6th</b><br>College (1-4 or 5+) <b>INSPECTOR</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>INSPECTOR</b>  |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>TEXTILE</b>  |  |  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>FRANK NALL</b>   |  |  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>UNKNOWN</b>   |  |   |  |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>JEANNE MARIE LONG</b>   |  |  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>RD# 3 TD#23, FRANKFORD, DELAWARE 19945</b>  |  |   |  |  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>CHESTER RURAL CEMETERY 1/30/96</b>  |  |   |  | 20c. LOCATION — City or Town, State<br><b>CHESTER, PA.</b>  |  |  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>MELSON FUNERAL SERVICES, LTD.<br/>FRANKFORD, DELAWARE 19945</b>  |  |   |  |  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><br>a. <b>pulmonary embolism</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>b. <b>perforated gastric ulcer</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>d.<br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Approximate Interval Between Onset and Death<br><b>5 m. - 1 hr.</b><br><b>2 weeks</b> |  |  |  |   |  |   |  |   |  |  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>   |  |  |  |   |  |   |  |   |  |  |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 28. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |  |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO     |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  |
|  |  |  |  | 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)  |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                        |  |  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |   |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  |  |  |   |  | 29c. LICENSE NUMBER<br><b>444283</b>  |  |   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/25/96</b>                     |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Robert D. Durkin<br/>9733 Herkimer Drive<br/>Berlin, MD</b>  |  |  |  |   |  |   |  |   |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>JAN 31 1996</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>  |  |   |  |   |  |  |  |   |  |

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04782

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Geraldine Morton Lomax</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 27 1996</b>  |  | 3. TIME OF DEATH<br><b>1545 P M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>231-40-7844</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>61</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>August 19, 1934</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>PENINSULA REGIONAL MEDICAL CENTER</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>SALISBURY</b>   |  | 9c. COUNTY OF DEATH<br><b>WICOMICO</b>  |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |  |
| 10a. STATE<br><b>MD</b>  |  | 10b. COUNTY<br><b>Wicomico</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Salisbury</b>   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br><b>1109 Bryn Mawr Avenue</b>   |  |  |  | 10f. ZIP CODE<br><b>21801</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br><b>Afro-American</b>  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (8-12) <b>12</b><br>College (1-4 or 5+) <b>Unknown</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Factory</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Perdue, Inc.</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Professor Morton</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Emma Douglas</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Priscilla Morton</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1109 Bryn Mawr Avenue — Salisbury, MD 21801</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Green Acres Memorial Park 2/3 Salisbury, MD</b>  |  | DATE<br><b>2/3</b>  |  | 20c. LOCATION — City or Town, State<br><b>Salisbury, MD</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Williamson Eluharty Funeral Service - 917 W. Isabella St. P. O. B. 1574 - Salisbury, MD 21801-1574</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  | a. <b>HYPOXEMIA</b>  |  |   |  | Approximate interval Between Onset and Death<br><b>24 hours</b>   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  | b. <b>END STAGE CARDIOMYOPATHY</b>   |  |   |  | Approximate interval Between Onset and Death<br><b>7 days</b>   |  |
|  |  | c. _____   |  |   |  |   |  |
|  |  | d. _____   |  |   |  |   |  |
|  |  | d. _____   |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
|  |  | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br> <b>MD</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D44061</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>January 27 1996</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Akwasi Appan MD 540 RIVERSIDE DRIVE SUITE 4 SALISBURY MD 21801</b>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 05 1996</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>  |  |   |  |



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR   |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 96 04783  |  |   |  |  |  |                                   |  |
|--|--|--|--|---|--|--|--|---|--|---|--|--|--|-----------------------------------|--|
| CERTIFICATE OF DEATH   |  |  |  | REG. NO.  |  |  |  |   |  |   |  |  |  |                                   |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Cecil Edward LEWIS   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>February 6, 1996  |  |  |  | 3. TIME OF DEATH<br>1:25 P M  |  |   |  |  |  |                                   |  |
| 4. SOCIAL SECURITY NUMBER<br>235-34-5541   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>70 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS                           |  | IF UNDER 24 HRS.<br>HOURS MIN.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>Jan. 8, 1926 |  | 8. BIRTHPLACE (State or Foreign Country)<br>West Virginia                            |  |                                   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Dennett Road Manor Nursing Home  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Oakland  |  |  |  | 9c. COUNTY OF DEATH<br>Garrett  |  |   |  |  |  |                                   |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |  |  |   |  |   |  |  |  |                                   |  |
| 10a. STATE<br>WV   |  | 10b. COUNTY<br>Preston   |  | 10c. CITY, TOWN OR LOCATION<br>Aurora   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |   |  |  |  |                                   |  |
| 10e. STREET AND NUMBER<br>Rt. 1, Box 345   |  |  |  | 10f. ZIP CODE<br>26705  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  |   |  |  |  |                                   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>WW II   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White   |  |   |  |  |  |                                   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>8th   |  | 15b. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Owner/Contractor  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Owner/Contractor   |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Truck Stop/Construction   |  |   |  |  |  |                                   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>James Harrison Lewis  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Edna Alice Blamble   |  |  |  |   |  |   |  |  |  |                                   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Tammy Lewis  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>77 Henry Clay Drive, Oakland, Maryland 21550   |  |  |  |   |  |   |  |  |  |                                   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Texas Cemetery  |  | DATE<br>2/9   |  | 20c. LOCATION — City or Town, State<br>Horseshoe Run, WV |  |   |  |   |  |  |  |                                   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Bradley H. Stewart  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Stewart Funeral Home<br>32 S. Second St., Oakland, MD 21550   |  |  |  |   |  |   |  |  |  |                                   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  | a. Multiple Myeloma<br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br><br>d.   |  |  |  | Approximate Interval Between Onset and Death<br>1 Year  |  |   |  |  |  |                                   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Congestive Heart Failure   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |   |  |  |  |                                   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M                            |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                     |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>[Signature]   |  | 29c. LICENSE NUMBER<br>D42464   |  | 29d. DATE SIGNED (Month, Day, Year)<br>2/6/96            |  |   |  |   |  |  |  |                                   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>S. Savopoulos, 1104 East State St., Terra Alta, WV 26764  |  |  |  | 31. DATE FILED (Month, Day, Year)<br>FEB 16 1996  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>[Signature]  |  |   |  |  |  |                                   |  |

2071 - 8

1 - FOR  
STATE  
REGISTRAR

96 04784

REG. NO.

OHMN-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 6876 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or other traumatic event, the medical examiner must be notified at once.**

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04785

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Charles Lindbergh Lowe

2. Date of Death

January 28, 1996

3. Time of Death

3:10 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

216-22-8473

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

68

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
May 21, 1927

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9003 Reich's Ford Road

10f. Zip Code

21704

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates

Jul 27, 1944 - July 20, 1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)  
General contractor

16b. Kind of Business/Industry

Contracting

17. Father's Name (First, Middle, Last)

Francis Peary Lowe

18. Mother's Name (First, Middle, Maiden Surname)

Carrie May Best

19a. Informant's Name/Relationship (Type, Print)

Doris M. Lowe (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9003 Reich's Ford Road, Frederick, Md. 21704

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Garrison Forest Veterans Cem. Feb. 1, 1996

Date

20c. Location - City or Town, State

Owenings Mills,  
Maryland

21. Signature of Funeral Service Licensee

Richard C. C. Basford M00021

22. Name and Address of Facility

Keeney and Basford Funeral Home  
106 East Church Street, Frederick, Md. 21701

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. PSEUDOMONAS SEPTIS

Due to (or as a consequence of):

b. PNEUMONIA

Due to (or as a consequence of):

c. METASTATIC SQUAMOUS CELL LUNG CANCER

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

d.

Approximate Interval Between Onset and Death

4 DAYS

4 DAYS

2 MONTHS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

SEVERE NEUTROPENIA

CORONARY ARTERY DISEASE

PRERENAL AZOTHEMIA

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Bryan M. O'Connor, MD

29c. License number

D31761

29d. Date signed (Month, Day, Year)

1/28/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BRYAN M. O'CONNOR MD 501 W. SEVENTH ST, FREDERICK, MD 21701

31. Date filed (Month, Day, Year)

JAN 31 1996

32. Registrar's Signature

John Michael Ruffalo

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

EBV 1/1

1. The first part of the document is a list of names and addresses. The names are written in a cursive hand, and the addresses are written in a more formal, printed hand. The list is organized into two columns, with names on the left and addresses on the right.

2. The second part of the document is a list of names and addresses. The names are written in a cursive hand, and the addresses are written in a more formal, printed hand. The list is organized into two columns, with names on the left and addresses on the right.

3. The third part of the document is a list of names and addresses. The names are written in a cursive hand, and the addresses are written in a more formal, printed hand. The list is organized into two columns, with names on the left and addresses on the right.

4. The fourth part of the document is a list of names and addresses. The names are written in a cursive hand, and the addresses are written in a more formal, printed hand. The list is organized into two columns, with names on the left and addresses on the right.

5. The fifth part of the document is a list of names and addresses. The names are written in a cursive hand, and the addresses are written in a more formal, printed hand. The list is organized into two columns, with names on the left and addresses on the right.

6. The sixth part of the document is a list of names and addresses. The names are written in a cursive hand, and the addresses are written in a more formal, printed hand. The list is organized into two columns, with names on the left and addresses on the right.

7. The seventh part of the document is a list of names and addresses. The names are written in a cursive hand, and the addresses are written in a more formal, printed hand. The list is organized into two columns, with names on the left and addresses on the right.

8. The eighth part of the document is a list of names and addresses. The names are written in a cursive hand, and the addresses are written in a more formal, printed hand. The list is organized into two columns, with names on the left and addresses on the right.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04786

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Agnes McKellican</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>Feb</b> DAY <b>5</b> YEAR <b>96</b>  |  | 3. TIME OF DEATH<br><b>1035 A M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>218-40-7567</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>83</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>June 22, 1912</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Scotland</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Dorchester General Hospital</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Cambridge</b>  |  |
| 9c. COUNTY OF DEATH<br><b>Dorchester</b>   |  |  |  | 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Dorchester</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Cambridge</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>6101 Twin Point Cove Road</b>   |  |
| 10f. ZIP CODE<br><b>21613</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>Scotland</b>  |  | 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:                                       |  |  |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>   |  |  |  | 15. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Housekeeping</b>  |  |  |  |
| 16. KIND OF BUSINESS/INDUSTRY<br><b>Family Service</b>   |  |  |  | 17. FATHER'S NAME (First, Middle, Last)<br><b>Unknown</b>   |  |  |  |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Unknown</b>  |  |  |  | 19a. INFORMANT'S NAME (Type/Print)<br><b>Mary O'Connell</b>   |  |  |  |
| 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6101 Twin Point Cove Rd., Cambridge, MD. 21613</b>   |  |  |  | 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  |  |  |
| 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Cambridge Crematory 2-8</b>  |  |  |  | 20c. LOCATION — City or Town, State<br><b>Cambridge, MD.</b>  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Mary O'Connell</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Curran-Bromwell Funeral Home, P.A.<br/>308 High St., Cambridge, MD. 21613</b>  |  |  |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Respiratory Failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. Chronic obstructive pulmonary disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d.</b><br><br>Approximate Interval Between Onset and Death<br><b>4 days</b><br><b>years</b><br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Acute Pneumonia</b><br><b>Congestive Heart Failure</b><br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>  |  |  |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Edmund J. MacLaughlin MD</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>D-28209</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>Feb 5, 1996</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Edmund J. MacLaughlin 4 Aurora St Cambridge, Md 21613</b>  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 08 1996</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Jane A. ...</i>   |  |  |  |

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04787

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MILDRED CATHERINE MILLS

2. Date of Death

Month Day Year  
FEBRUARY 1, 1996

3. Time of Death

10:45AM

4a. Facility Name (If not institution, give street and number)

5715 EAST NEW MARKET-MT. HOLLY ROAD

4b. City, Town, or Location of Death

EAST NEW MARKET

4c. County of Death

DORCHESTER

Funeral  
Director

5. Social Security Number

219-44-1746

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
JUNE 12, 1911

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

DORCHESTER

10c. City, Town or Location

EAST NEW MARKET

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5715 EAST NEW MARKET-MT. HOLLY ROAD

10f. Zip Code

21631

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
11

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

-

17. Father's Name (First, Middle, Last)

THOMAS LEONARD PHILLIPS

18. Mother's Name (First, Middle, Maiden Surname)

LENA McNAMARA

19a. Informant's Name/Relationship (Type, Print)

HELEN V. KIRBY

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

215 KILLARNEY ROAD, CAMBRIDGE, MD 21613

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

EAST NEW MARKET CEMETERY

Date

2/4

20c. Location - City or Town, State

EAST NEW MARKET, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

ZELLER FUNERAL HOME, P. O. BOX 207

106 MAIN STREET, EAST NEW MARKET, MD 21631

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac Arrhythmia (Presumed)

Due to (or as a consequence of):

b. Type II Diabetes

Due to (or as a consequence of):

c. Hypertension

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

5 min.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

J26388

29d. Date signed (Month, Day, Year)

02-02-1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Michael Finkbeiner 302 Collins Hurlock MD 21643

31. Date filed (Month, Day, Year)

FEB 07 1996

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

100701

1. The first part of the report is a general introduction to the subject.

2. The second part is a detailed description of the methods used.

3. The third part is a discussion of the results obtained.

4. The fourth part is a conclusion.

5. The fifth part is a list of references.

6. The sixth part is a list of figures.

7. The seventh part is a list of tables.

8. The eighth part is a list of appendices.

9. The ninth part is a list of footnotes.

10. The tenth part is a list of symbols.

ITEMS: 23 PART I, 27, PER MEO State of Maryland / Department of Health and Mental Hygiene  
FILM G-732 2/22/96 t.t

## Certificate of Death

Reg. No.

96 04788

|   |   |   |   |  |  |   |  |  |  |                               |  |  |
|---|---|---|---|--|--|---|--|--|--|-------------------------------|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>BARBARA LOUISE MULDER   |   |   |  | 2. Date of Death<br>Month Day Year<br>FEB. 09, 1996  |   | 3. Time of Death<br>3:15 PM                        |  |  |                               |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>49 BENONI CIRCLE  |   |   |  | 4b. City, Town, or Location of Death<br>BALTIMORE  |   | 4c. County of Death<br>Baltimore                   |  |  |                               |  |  |
| Funeral<br>Director   | 5. Social Security Number<br>218-72-9398  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>37 Yrs.  |   | 8. Date of Birth (Month, Day, Year)<br>May 4, 1958 |  | 9. Birthplace (State or Foreign Country)<br>Illinois   |                               |  |  |
|   | Usual Residence of Decedent   |   |   |  |  |   |  |  |  |                               |  |  |
| To Be Completed by Funeral Director   | 10a. State<br>MD  |   | 10b. County<br>Baltimore  |  | 10c. City, Town or Location<br>Baltimore   |   |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |                               |  |  |
|   | 10e. Street and Number<br>49 Benoni Circle  |   |   |  | 10f. Zip Code<br>21220   |   | 10g. Citizen of What Country?<br>U.S.A.            |  |  |                               |  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |                               |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+)   |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>General Labor   |   |  | 16b. Kind of Business/Industry<br>Services Industries  |  |                               |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>James M. Dawson  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Jessie D. Doyle   |   |  |  |  |                               |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Jessie D. Dawson  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>212 York Rd., Jacobus, PA 17407   |   |  |  |  |                               |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Dulaney Valley Memorial Gardens  |   | Date<br>Feb. 13, 1996                              |  | 20c. Location - City or Town, State<br>Timonium, MD 21093  |                               |  |  |
|   | 21. Signature of Funeral Service Licensee<br>   |   |   |  | 22. Name and Address of Facility<br>J.J. HARTENSTEIN MORTUARY, INC<br>24 Second St., New Freedom, PA 17349   |   |  |  |  |                               |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. SEIZURE DISORDER<br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  |  |   |  |  |  |                               | Approximate Interval Between Onset and Death |  |
|   | Physician<br>/Medical<br>Examiner   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |                               |  |  |
|   |   |   |   |  |  | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |                               |  |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |   |  |  |  |                               |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                      |  | 28d. Describe how Injury occurred  |  |                               |  |  |
|   |   |   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |                               |  |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |   |  |  |   |  |  |  |                               |  |  |
| 29b. Signature and title of certifier<br>   |   |   |   | 29c. License number<br>O.C.M.E.  |  | 29d. Date signed (Month, Day, Year)<br>FEB. 10, 1996  |  |  |  |                               |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>J. Aaron Locke, MD 111 Penn Street, Baltimore, Maryland 21201   |   |   |   |  |  |   |  |  |  |                               |  |  |
| 31. Date filed (Month, Day, Year)<br>FEB 21 1996  |   |   |   |  |  |   |  |  |  | 32. Registrar's Signature<br> |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

[REDACTED]

[REDACTED]

[REDACTED]

## Certificate of Death

Reg. No. 96 04789

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LLOYD ALBERT MONEYSMAKER JR.

2. Date of Death

Month Day Year  
FEB. 05, 1996

3. Time of Death

08:57 A

Funeral  
Director

4a. Facility Name (If not Institution, give street and number)

NAVAL HOSPITAL PATUXENT RIVER

4b. City, Town, or Location of Death

Patuxent River

4c. County of Death

ST. MARYS

5. Social Security Number

214-58-0098

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

42

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Aug. 22, 1953

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

St. Mary's

10c. City, Town or Location

Great Mills

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

P.O. Box 293 Route 5

10f. Zip Code

20634

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th grade

College (1-4 or 5+)

18e. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Quality Control Inspector

16b. Kind of Business/Industry

General Electric, Corp.

17. Father's Name (First, Middle, Last)

Lloyd Albert Moneysmaker, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Blanche May Duke

19e. Informant's Name/Relationship (Type, Print)

Tammy E. Moneysmaker (Spouse)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 293 Route 5, Great Mills, Maryland 20634

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Evergreen Memorial Gardens 2/9/96

Date

20c. Location - City or Town, State

Lexington Park, Maryland

21. Signature of Funeral Service Licensee

*Michael K. Gardiner*

22. Name and Address of Facility

Mattingley-Gardiner Funeral Home, P.A.

P.O. Box 270, Leonardtown, Maryland 20650

23e. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. NARCOTIC INTOXICATION

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24e. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

XX Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☒ Could not be determined

28e. Date of Injury

(Month, Day Year)

FOUND: 2-5-96

28b. Time of Injury

8:00 A M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

FOUND: RESIDENCE

28d. Describe how injury occurred

UNKNOWN

28f. Location (Street and Number or Rural Route Number, City or Town, State)

68-M CALVERT LEXINGTON PARK, MD.

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.XX ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

*Theodore M. King*

29c. License number

OCME

29d. Date signed (Month, Day, Year)

FEB. 06, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

*Theodore M. King*

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

FEB 23 1996

32. Registrar's Signature

*John A. Russell*State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

20747 31





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 96 04790

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Elizabeth MURRAY

2. Date of Death

Month 2 Day 6 Year 96

3. Time of Death

10:30 a.m.

4a. Facility Name (If not institution, give street and number)

11403 Stonecroft Court 112-A

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

Funeral  
Director

5. Social Security Number

214-09-5391

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

May 22, 1911

9. Birthplace (State or Foreign Country)

Hagerstown, Md.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11403 Stonecroft Court 112-A

10f. Zip Code

21740

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
unknownCollege (1-4 or 5+)  
unknown

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

machine operator

16b. Kind of Business/Industry

clothing mfg.

17. Father's Name (First, Middle, Last)

John C. Heil

18. Mother's Name (First, Middle, Maiden Surname)

Nina Myrtle Fishack

19a. Informant's Name/Relationship (Type, Print)

Cleveland Milburn

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

920 Queen Anne's Court Hagerstown, Maryland 21740

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Lawn Mem. Park

Date

2-10-96

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

Scott H. Minnich

22. Name and Address of Facility

MINNICH FUNERAL HOME

415 E. Wilson Blvd., Hagerstown, Md. 21740

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Hypertensive Atherosclerotic — 40 years

Due to (or as a consequence of):

Cardiovascular disease

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

John C. Heil MD

29c. License number

A73623

29d. Date signed (Month, Day, Year)

2/6/96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Frederick H. Kass III MD 1799 Powell Rd Hagerstown Md

31. Date (Month, Day, Year)

FEB 8 1996

32. Registrar's Signature

John C. Heil MD

21740

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

0219

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 04791

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Charles Thomas Myers

2. Date of Death

Month Day Year  
Feb 3 96

3. Time of Death

0855 AM

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

Funeral  
Director

5. Social Security Number

215-26-7837

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

66

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec 27, 29

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

368 South Locust Street

10f. Zip Code

21740

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married  
☐ Widowed ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No  
If Yes, Give Year or Dates

1951-53

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:  
White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (14 or 5+)

11

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Warehouse Clerk

16b. Kind of Business/Industry

Roche-Hull Co.

17. Father's Name (First, Middle, Last)

Jesse Paul Myers

18. Mother's Name (First, Middle, Maiden Surname)

Corinne Suffecool

19a. Informant's Name/Relationship (Type, Print)

Charles S. Myers

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

17036 VA. Ave. Williamsport, MD 21795

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Paul Cemetery

Date

2-7-96

20c. Location - City or Town, State

Clear Spring, MD

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

Thompson Funeral Home, Inc.

P.O. Box 310 Clear Spring, MD 21722

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Respiratory Failure

Due to (or as a consequence of):

Hours

b. Bronchogenic Carcinoma

Due to (or as a consequence of):

Months

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atrial Fibrillation

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

Hospital:

☒ Inpatient

☐ ER/Outpatient

☐ DOA

Other:

☐ Nursing Home

☐ Residence

☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

*[Signature]*

29c. License number

D21457

29d. Date signed (Month, Day, Year)

2/3/96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

ABDUL WATKINS MD - 12821-OAK HILL AVE HAGERSTOWN MD 21742

31. Date filed (Month, Day, Year)

FEB 6 1996

32. Registered Signature

*[Signature]*

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

185

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04792

|  |  |  |  |   |  |   |  |  |  |  |  |   |  |
|--|--|--|--|---|--|---|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Mary Edith Martin  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>February 2 1996   |  |   |  | 3. TIME OF DEATH<br>4:00 P M   |  |  |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br>217-09-9729   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>85 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>June 18, 1910                              |  | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Reeder's Memorial Home   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Boonsboro  |  |   |  | 9c. COUNTY OF DEATH<br>Washington  |  |  |  |   |  |
| 10a. STATE<br>Maryland   |  |  |  | 10b. COUNTY<br>Washington   |  |   |  | 10c. CITY, TOWN OR LOCATION<br>Hagerstown  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br>11 West Baltimore Street   |  |  |  | 10f. ZIP CODE<br>21740  |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |  |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: white                     |  |  |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) unknown<br>College (1-4 or 5+) unknown   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>meat cutter & bookkeeping  |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>meat market  |  |  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>John Cornell  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Minnie Limburg   |  |   |  |  |  |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Mr. Charles L. Martin  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>11101 Lakeside Court Lot 190, Hagerstown, MD 21740   |  |   |  |  |  |  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Hagerstown Crematory   |  |   |  | DATE<br>2-3-96   |  | 20c. LOCATION — City or Town, State<br>Hagerstown, Maryland  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Scott Minnich</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Minnich Funeral Home<br>415 E. Wilson Blvd., Hagerstown, MD 21740   |  |   |  |  |  |  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. <i>DEHYDRATION</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <i>MALNUTRITION</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <i>CHRONIC GASTRITIS AND DIVERTICULITIS</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |   |  |  |  | Approximate Interval Between Onset and Death<br>2 MONTHS<br>4 MONTHS<br>2 YEARS.   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>ATHROSCLEROTIC CARDIO VASCULAR DISEASE</i><br><i>CONGESTIVE HEART FAILURE</i>   |  |  |  |   |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |   |  |   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  |  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M                  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Zafar Malik</i>   |  |   |  | 29c. LICENSE NUMBER<br>D44996  |  | 29d. DATE SIGNED (Month, Day, Year)<br>FEB 3, 1996   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Dr. Zafar Malik 20311 Lappans Road, Boonsboro, Maryland 21713   |  |  |  |   |  |   |  |  |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>FEB 6 1996  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>J. B. Smith</i>   |  |   |  |  |  |  |  |   |  |

Section 20

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 96 04793

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Marie A. Morth

2. Date of Death  
Month Day Year  
February 4, 19963. Time of Death  
1:30 p.m.

4a. Facility Name (If not institution, give street and number)

Homewood Retirement Center

4b. City, Town, or Location of Death

Williamsport

4c. County of Death

Washington

Funeral  
Director

5. Social Security Number

171-18-9327

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Aug. 17, 1908

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State  
Maryland10b. County  
Washington10c. City, Town or Location  
Williamsport

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

16505 Virginia Avenue

10f. Zip Code

21795

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

homemaker

16b. Kind of Business/Industry

her own

17. Father's Name (First, Middle, Last)

William Broslat

18. Mother's Name (First, Middle, Maiden Surname)

Augusta Beiter

19a. Informant's Name/Relationship (Type, Print)

Pinkertown Funeral Home

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1014 California Ave., Pittsburgh, Pa. 15202

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Union Dale Cemetery

Date

2-7-96

20c. Location - City or Town, State

Pittsburgh, Pa.

21. Signature of Funeral Service Licensee

Scott M. Munnich

22. Name and Address of Facility

MINNICH FUNERAL HOME

415 E. Wilson Blvd., Hagerstown, Md. 21740

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Aspiration pneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of injury (Month, Day Year)

28b. Time of injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

John D. Munnich

29c. License number

D26806

29d. Date signed (Month, Day, Year)

2/5/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hagerstown 21742 Hagerstown MD 21742

Date filed (Month, Day, Year)

FEB 6 1996

31. Registrar's Signature

John D. Munnich

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Sept 22

at Cambridge Mass

Dear Mr. Brewster

I have just received your letter of the 19th inst. and am glad to hear from you. I am well and hope this finds you the same. I have been very busy lately with my work and have not had time to write you more fully. I am, however, very interested in the work you are doing and hope to hear from you again soon.

I am, Sir, very respectfully,  
Your obedient servant,  
J. A. Allen

Sept 22

Sept 22

Sept 22

Sept 22



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR   |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 96 04794  |  |   |  |  |  |   |  |
|--|--|--|--|---|--|---|--|---|--|--|--|---|--|
| CERTIFICATE OF DEATH   |  |  |  | REG. NO.  |  |   |  |   |  |  |  |   |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Howard Thomas Myers</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 31, 1996</b>   |  | 3. TIME OF DEATH<br><b>7:42 AM</b>  |  |   |  |  |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>212-14-7485</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>88</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>March 14 1907</b>                                     |  |   |  |  |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Reeders Memorial Home</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Boonsboro</b>   |  | 9c. COUNTY OF DEATH<br><b>Washington</b>  |  |   |  |  |  |   |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Washington</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Boonsboro</b>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |   |  |  |  |   |  |
| 10e. STREET AND NUMBER<br><b>141 S. Main Street</b>  |  |  |  | 10f. ZIP CODE<br><b>21713</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  |  |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                      |  |   |  |  |  |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>0</b>   |  | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Owner</b>   |  | 15b. KIND OF BUSINESS/INDUSTRY<br><b>Grocery Store</b>  |  |   |  |   |  |  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Charles A. Myers</b>   |  |  |  | 16. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Blanche Crampton</b>  |  |   |  |   |  |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Arthur Myers</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>22 Manor Drive #A3 Hagerstown, Maryland 21740</b>   |  |   |  |   |  |  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Cedar Lawn Memorial Park 2-1-96</b>  |  | 20c. LOCATION — City or Town, State<br><b>Hagerstown, Maryland</b>  |  |   |  |   |  |  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Scott M. Minnick</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Minnich Funeral Home<br/>415 E. Wilson Blvd. Hagerstown, Md. 21740</b>   |  |   |  |   |  |  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><b>pneumonia - aspiration</b><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>cerebrovascular accident</b><br><b>diabetes - type II</b> |  |  |  |   |  |   |  | Approximate Interval Between Onset and Death<br><b>5 days to 10 months</b>                            |  |  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/></b>   |  |  |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |   |  |  |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  |   |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |   |  |  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>R. Guedenet</b>   |  | 29c. LICENSE NUMBER<br><b>D32518</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>1/31/96</b> |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Dr. Robert Guedenet 100 Geeting Lane Keedysville, Maryland 21756 301-432-2222</b>  |  |  |  |   |  |   |  | 31. FILED (Month, Day, Year)<br><b>FEB 1 1996</b>   |  | 32. REGISTRAR'S SIGNATURE<br><b>J. H. [Signature]</b>  |  |   |  |

8156



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04795

|  |  |  |  |   |  |   |  |   |  |   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Estella Jeanette Meck  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>February 10 1996  |  |   |  | 3. TIME OF DEATH<br>1:50 a m  |  |   |  |   |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br>213-20-5035   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>72 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS.<br>HOURS MIN.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>March 26, 1923 Maryland |  | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Union Hospital of Cecil County   |  |  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Elkton   |  |   |  | 9c. COUNTY OF DEATH<br>Cecil                                      |  |   |  |  |  |
| 10a. STATE<br>Maryland   |  |  |  | 10b. COUNTY<br>Cecil  |  |   |  | 10c. CITY, TOWN OR LOCATION<br>Elkton   |  |   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO       |  |  |  |
| 10e. STREET AND NUMBER<br>857 East Old Philadelphia Road   |  |  |  |   |  | 10f. ZIP CODE<br>21921  |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>United States                    |  |   |  |  |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  |  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White  |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 7 College (1-4 or 5+) 7  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Assembly Line Worker   |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Fireworks Manufacturer  |  |   |  |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Joseph Dickerson Meck   |  |  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Rhoda Elsie Barnes   |  |   |  |   |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Anna Meck Stacy  |  |  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>857 East Old Philadelphia Road, Elkton, MD 21921 |  |   |  |   |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>North East Methodist Cem. 2/12   |  |   |  | 20c. LOCATION — City or Town, State<br>North East, Maryland   |  |   |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>Crouch Funeral Home<br>127 South Main Street, North East, MD 21901  |  |   |  |   |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>COPD</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <u>hypertension</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <u>Arteriosclerosis</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |   |  |   |  |   |  | Approximate interval Between Onset and Death  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  |   |  |   |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |   |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide  |  |  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED                                 |  |   |  |  |  |
| 29a. CERTIFIER<br>(Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  |   |  | 29c. LICENSE NUMBER<br>MD D44716  |  | 29d. DATE SIGNED (Month, Day, Year)<br>2/12/96                    |  |   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Dr. Jose MA 111 W. High Street. Elkton MD. 21921  |  |  |  |   |  |   |  |   |  |   |  |   |  |  |  |
| 31. DATE FILED<br>FEB 12 1996  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |   |  |   |  |   |  |   |  |  |  |

2052



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR   |  |   |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 96 04796   |  |                  |  |  |  |
|--|--|---|--|--|--|---|--|--|--|------------------|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)   |  |   |  | 2. DATE OF DEATH   |  |   |  | 3. TIME OF DEATH   |  |                  |  |  |  |
| Prentis Morris   |  |   |  | February 9, 1996   |  |   |  | 8:20 A M   |  |                  |  |  |  |
| 4. SOCIAL SECURITY NUMBER  |  | 5. SEX  |  | 8. AGE (In yrs. last birthday)   |  | IF UNDER 1 YEAR   |  | IF UNDER 24 MRS.   |  | 7. DATE OF BIRTH |  | 8. BIRTHPLACE (State or Foreign Country) |  |
| 229-34-6971  |  | 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F    |  | 92 YRS.  |  | MONTHS DAYS HOURS MIN.  |  |  |  | May 8, 1903      |  | VA                                       |  |
| 9a. FACILITY NAME (If not Institution, give street and number)   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH  |  |   |  | 9c. COUNTY OF DEATH  |  |                  |  |  |  |
| Physicians Memorial Hospital   |  |   |  | La Plata   |  |   |  | Charles  |  |                  |  |  |  |
| RESIDENCE OF DECEDENT  |  |   |  | 10c. CITY, TOWN OR LOCATION  |  |   |  | 10d. INSIDE CITY LIMITS?   |  |                  |  |  |  |
| 10a. STATE   |  | 10b. COUNTY   |  | 10c. CITY, TOWN OR LOCATION  |  | 10d. INSIDE CITY LIMITS?  |  | 10e. CITIZEN OF WHAT COUNTRY?  |  |                  |  |  |  |
| MD   |  | Charles   |  | White Plains   |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | U.S.A.   |  |                  |  |  |  |
| 10a. STREET AND NUMBER   |  |   |  | 10f. ZIP CODE  |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?  |  |                  |  |  |  |
| 225 Dump Rd.   |  |   |  | 20695  |  |   |  | U.S.A.   |  |                  |  |  |  |
| 11. MARITAL STATUS   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?                             |  | 13. WAS DECEDENT OF HISPANIC ORIGIN?   |  | 14. RACE — American Indian, Black, White, etc.                          |  |  |  |                  |  |  |  |
| 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married  |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | Specify: White  |  |  |  |                  |  |  |  |
| 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | IF YES, GIVE WAR OR DATES   |  | Specify:   |  |   |  |  |  |                  |  |  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)  |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)   |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |                  |  |  |  |
| Elementary/Secondary (0-12) College (1-4 or 5 +)   |  |   |  | Farmer   |  |   |  | Farming  |  |                  |  |  |  |
| 0  |  |   |  |  |  |   |  |  |  |                  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)  |  |   |  |  |  |                  |  |  |  |
| John T. Morris   |  |   |  | Leouranie Morris   |  |   |  |  |  |                  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)  |  |   |  |  |  |                  |  |  |  |
| Frankie Knight   |  |   |  | Apt. 11 Gallery Place #11 Waldorf, MD 20602  |  |   |  |  |  |                  |  |  |  |
| 20a. METHOD OF DISPOSITION   |  |   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)  |  |   |  | 20c. LOCATION — City or Town, State  |  |                  |  |  |  |
| 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State  |  |   |  | Evergreen Cem.   |  |   |  | 2/12/96 Stanardsville, VA  |  |                  |  |  |  |
| 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |   |  |  |  |   |  |  |  |                  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  |  |   |  | 22. NAME AND ADDRESS OF FACILITY   |  |   |  |  |  |                  |  |  |  |
| David C. Echols MO0945   |  |   |  | AREHART-ECHOLS FUNERAL HOME, INC.  |  |   |  |  |  |                  |  |  |  |
|  |  |   |  | P.O. Box 567 LaPlata, MD 20646   |  |   |  |  |  |                  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  | Approximate Interval Between Onset and Death   |  |   |  |  |  |                  |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  |   |  | couple of yrs  |  |   |  |  |  |                  |  |  |  |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  |  |   |  | CHRONIC OBSTRUCTIVE Pulmonary Disease - YRS  |  |   |  |  |  |                  |  |  |  |
| a. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |  |  |   |  |  |  |                  |  |  |  |
| b. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |  |  |   |  |  |  |                  |  |  |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |  |  |   |  |  |  |                  |  |  |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |  |  |   |  |  |  |                  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?   |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  |  |                  |  |  |  |
| Pulmonary hypertension   |  |   |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |   |  | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                 |  |                  |  |  |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>  |  |   |  |  |  |   |  |  |  |                  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?   |  |   |  | 26. PLACE OF DEATH (Check only one)  |  |   |  |  |  |                  |  |  |  |
| 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |   |  | HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |                  |  |  |  |
| 27. MANNER OF DEATH  |  |   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  |   |  | 28b. TIME OF INJURY  |  |                  |  |  |  |
| 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |  |   |  |  |  |   |  | M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO               |  |                  |  |  |  |
|  |  |   |  | 28c. INJURY AT WORK?   |  |   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |                  |  |  |  |
|  |  |   |  |  |  |   |  |  |  |                  |  |  |  |
|  |  |   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |  |                  |  |  |  |
|  |  |   |  |  |  |   |  |  |  |                  |  |  |  |
| 29a. CERTIFIER (Check only one)  |  |   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER  |  |   |  | 29c. LICENSE NUMBER  |  |                  |  |  |  |
| 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  | Attending  |  |   |  | D-44436  |  |                  |  |  |  |
| 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |  |  |   |  | 29d. DATE SIGNED (Month, Day, Year)  |  |                  |  |  |  |
|  |  |   |  |  |  |   |  | February 09 1996   |  |                  |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  |  |   |  | 31. DATE FILED (Month, Day, Year)  |  |   |  | 32. REGISTRAR'S SIGNATURE  |  |                  |  |  |  |
| Ashvinkumar Patel, M.D.  |  |   |  | FEB 12 1996  |  |   |  | Julia Davidson Randall   |  |                  |  |  |  |
|  |  |   |  |  |  |   |  |  |  |                  |  |  |  |

2017-18

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04797

|  |  |   |   |   |  |  |  |  |  |  |
|--|--|---|---|---|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>SYLVIA MORSELL   |   |   |   | 2. Date of Death<br>Month Day Year<br>FEBRUARY 2, 1996   |  |  |  | 3. Time of Death<br>9 10PM   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Prince George's Hospital Center  |   |   |   | 4b. City, Town, or Location of Death<br>Cheverly   |  |  |  | 4c. County of Death<br>Prince George's   |  |
| Funeral<br>Director  | 5. Social Security Number<br>217-88-7893   |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br>33 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>March 29, 1962                                |  | 9. Birthplace (State or Foreign Country)<br>Maryland   |  |
|  | Usual Residence of Decedent  |   |   |   |  |  |  |  |  |  |
| To Be Completed by Funeral Director  | 10e. State<br>Maryland   |   | 10b. County<br>Calvert  |   | 10c. City, Town or Location<br>Owings  |  |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
|  | 10e. Street and Number<br>410 Skinners Turn Road   |   |   |   | 10f. Zip Code<br>20736   |  |  |  | 10g. Citizen of What Country?<br>USA   |  |
|  | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: Black                                   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 Collegia (1-4 or 5+)   |   |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker   |  |  |  | 16b. Kind of Business/Industry<br>Own home   |  |
|  | 17. Father's Name (First, Middle, Last)<br>Charles D. Morsell  |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Mary Hicks  |  |  |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>Russell Holland, Jr./Friend  |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>390 Skinners Turn Rd. Owings, MD 20736  |  |  |  |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Mt. Hope UM Church Cem.   |   | 20c. Date<br>2/9/96  |  | 20d. Location - City or Town, State<br>Sunderland, MD                                |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br>Spencer E. Sewell   |   |   |   | 22. Name and Address of Facility<br>Sewell Funeral Home<br>1451 Dares Beach Rd. Prince Frederick, MD 20678   |  |  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Septic Shock<br>Due to (or as a consequence of):<br>b. Pneumonia<br>Due to (or as a consequence of):<br>c. End Stage Liver Disease<br>Due to (or as a consequence of):<br>d.<br>Approximate Interval Between Onset and Death<br>2 weeks<br>2 weeks<br>2 weeks |   |   |   |  |  |  |  |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |   |  |  |  |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |   |   |   |  |  |  |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |   |   |  |  |  |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |   |   |  |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |  |  |  |  |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |
|  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |  |  |
|  | 29e. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   |   |   |  |  |  |  |  |  |
|  | 29b. Signature and title of certifier<br>J. Catavenis, M.D.  |   |   |   | 29c. License number<br>D30318  |  |  |  | 29d. Date signed (Month/Day, Year)<br>2/4/96   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>J. Catavenis, M.D. Cheverly, MD  |  |   |   |   |  |  |  |  |  |  |
| State Registrar  |  | 31. Date filed (Month, Day, Year)<br>FEB - 9 1996 |   | 32. Registrar's Signature<br>John A. Davidson-Randall |  |  |  |  |  |  |

1971

1. The first part of the paper is devoted to a study of the properties of the function  $f(x)$  defined by the equation  $f(x) = \int_0^x f(t) dt$ . It is shown that  $f(x)$  is a constant function, and its value is determined by the initial condition  $f(0) = 1$ .

2. In the second part, we consider the problem of finding the maximum value of the function  $f(x)$  on the interval  $[0, 1]$ . It is shown that the maximum value is attained at  $x = 0$  and is equal to 1.

3. The third part of the paper is devoted to a study of the properties of the function  $f(x)$  defined by the equation  $f(x) = \int_0^x f(t) dt$ . It is shown that  $f(x)$  is a constant function, and its value is determined by the initial condition  $f(0) = 1$ .

4. In the fourth part, we consider the problem of finding the maximum value of the function  $f(x)$  on the interval  $[0, 1]$ . It is shown that the maximum value is attained at  $x = 0$  and is equal to 1.

5. The fifth part of the paper is devoted to a study of the properties of the function  $f(x)$  defined by the equation  $f(x) = \int_0^x f(t) dt$ . It is shown that  $f(x)$  is a constant function, and its value is determined by the initial condition  $f(0) = 1$ .

6. In the sixth part, we consider the problem of finding the maximum value of the function  $f(x)$  on the interval  $[0, 1]$ . It is shown that the maximum value is attained at  $x = 0$  and is equal to 1.

7. The seventh part of the paper is devoted to a study of the properties of the function  $f(x)$  defined by the equation  $f(x) = \int_0^x f(t) dt$ . It is shown that  $f(x)$  is a constant function, and its value is determined by the initial condition  $f(0) = 1$ .

8. In the eighth part, we consider the problem of finding the maximum value of the function  $f(x)$  on the interval  $[0, 1]$ . It is shown that the maximum value is attained at  $x = 0$  and is equal to 1.

9. The ninth part of the paper is devoted to a study of the properties of the function  $f(x)$  defined by the equation  $f(x) = \int_0^x f(t) dt$ . It is shown that  $f(x)$  is a constant function, and its value is determined by the initial condition  $f(0) = 1$ .

10. In the tenth part, we consider the problem of finding the maximum value of the function  $f(x)$  on the interval  $[0, 1]$ . It is shown that the maximum value is attained at  $x = 0$  and is equal to 1.

11. The eleventh part of the paper is devoted to a study of the properties of the function  $f(x)$  defined by the equation  $f(x) = \int_0^x f(t) dt$ . It is shown that  $f(x)$  is a constant function, and its value is determined by the initial condition  $f(0) = 1$ .

12. In the twelfth part, we consider the problem of finding the maximum value of the function  $f(x)$  on the interval  $[0, 1]$ . It is shown that the maximum value is attained at  $x = 0$  and is equal to 1.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR   |  |   |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   | REG. NO.   |  | 96 04798  |  |
|--|--|---|--|---|--|--|---|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>JOHN MESSICK</b>  |  |   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Feb. 1 1996</b>                   |   | 3. TIME OF DEATH<br>HOURS MIN.<br><b>9:55 A M</b>  |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>214-10-6963</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 6. AGE (In yrs. last birthday)<br><b>89</b> YRS. | IF UNDER 1 YEAR<br>MONTHS DAYS  | IF UNDER 24 HRS.<br>HOURS MIN.   | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>APR. 30, 1906</b>             |   | 8. BIRTHPLACE (State or Foreign Country)<br><b>MD.</b>                                     |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Salisbury Nuring &amp; Rehab Center</b>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Salisbury, Maryland</b>   |  |  | 9c. COUNTY OF DEATH<br><b>Wicomico</b>  |  |  |   |  |
| 10a. STATE<br><b>MD.</b>   |  | 10b. COUNTY<br><b>WICOMICO</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>SALISBURY</b>   |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |  |   |  |
| 10e. STREET AND NUMBER<br><b>6879 ZION CHURCH ROAD</b>   |  |   |  | 10f. ZIP CODE<br><b>21804</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                             |   |  |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b> |   |  |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6</b><br>College (1-4 or 5+) <b>6</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>MECHANIC</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>FARM EQUIPMENT</b>   |  |  |   |  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>JESS MESSICK</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>SUSAN MESSICK</b>   |  |  |   |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>ETHEL TAWES</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6877 ZION CHURCH ROAD, SALISBURY, MD. 21804</b>   |  |  |   |  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>SPRINGHILL MEMORY GARDENS 2/5</b>   |  | DATE<br><b>HEBRON, MD.</b>  |  | 20c. LOCATION — City or Town, State  |   |  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Gerald C. Bunch</i>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>BOUNDS FUNERAL HOME, SALISBURY, MD. 21804</b>  |  |  |   |  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death)</b> → <b>Pneumonia</b><br><b>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b><br>a. <b>CHF</b> DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>COPD</b> DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>d.<br><b>Approximate Interval Between Onset and Death</b><br><b>weeks</b><br><b>years</b><br><b>years</b> |  |   |  |   |  |  |   |  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH</b> YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |   |  |   |  |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |   |  |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO | 28d. DESCRIBE HOW INJURY OCCURED   |   |  |  |   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |  |   |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>William Robius, M.D.</i>   |  |   |  | 29c. LICENSE NUMBER<br><b>029349</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>2/1/96</b>                       |   |  |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>William Robius, M.D. 1104 HEALTHWAY DR., SALISBURY, MD. 21801</b>  |  |   |  |   |  |  |   |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 05 1996</b>  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |   |  |  |   |  |  |   |  |



|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <b>James Walter MacDonald Jr.</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>Feb</b> DAY <b>2</b> YEAR <b>96</b>   |  | 3. TIME OF DEATH<br><b>1502 M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>578-46-6850</b>  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>81</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>MAR 13 14</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Pennsylvania</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>North Arundel Hosp</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Glen Burnie</b>  |  |
| 9c. COUNTY OF DEATH<br><b>AA</b>   |  |  |  | 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Wicomico</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Delmar</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>29582 Foskey Lane</b>   |  |
| 10f. ZIP CODE<br><b>21875</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Chemical Engineer</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Fuels &amp; Lubes</b>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>John Walter MacDonald Sr.</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Minnie Mae Hart</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mary Elizabeth O'Connor MacDonald</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>29582 Foskey Lane, Delmar, MD 21875</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Salisbury Crematory</b>  |  | 20c. LOCATION — City or Town, State<br><b>Salisbury, MD</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>David A. Gompers</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Holloway Funeral Home</b><br><b>501 Snow Hill Rd., Salisbury, MD 21801</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Acute Cardiac Failure</b>   |  |  |  |  |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |  |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  |  |  |  |  |  |  |  |
| b. <b>Arteriosclerotic Heart Disease</b>   |  |  |  |  |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |  |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |  |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |  |  |  |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>William P. Jones, MD Deputy</i>  |  |  |  | 29c. LICENSE NUMBER<br><b>D06054</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>Feb 2 96</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>William P. Jones, MD 695 America 21035</b>   |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 05 1996</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2014-10-26

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04800

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Pauline ETTA MEIZLISH

2. Date of Death  
Month Day Year

January 7, 1996

3. Time of Death

3:00 am

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore county

5. Social Security Number

216-28-1276

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

65

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Aug. 11, 1930

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Queen Anne's

10c. City, Town or Location

Chester

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2723 Harrington Road

10f. Zip Code

21619

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
if Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

7

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Cashier

16b. Kind of Business/Industry

Retail

17. Father's Name (First, Middle, Last)

Martin McInturff

18. Mother's Name (First, Middle, Maiden Surname)

Myrtle Jewell

19a. Informant's Name/Relationship (Type, Print)

Jerome M. Meizlish  
Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2723 Harrington Rd.; Chester, Md. 21619

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)Jan. 12, 1996  
Md. Veterans Cemetery

Data

20c. Location - City or Town, State

Crownsville, Md.

21. Signature of Funeral Service Licensee

Chad M. Helfenbein

22. Name and Address of Facility

Tom Helfenbein Funeral Homes, PA  
106 Shamrock Rd., Chester, Md. 2161923a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Sepsis

Due to (or as a consequence of):

10 - 15 days

b. Renal Failure

Due to (or as a consequence of):

c. Gastric Stapeling and Lysis of Adhesions

Due to (or as a consequence of):

d. Duodenal Perforation

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Anita Aggarwal D.O.

29c. License number

P09627

29d. Date signed (Month, Day, Year)

January 10, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Anita Aggarwal, D.O. 9000 Franklin Square Drive, Baltimore, Maryland 21237

31. Date filed (Month, Day, Year)

JAN 19 1996

32. Registrar's Signature

John T. Anderson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

100

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04801

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Howard Alvin

Mills

2. Date of Death

Jan. 6, 1996

3. Time of Death

8:48 AM

4a. Facility Name (If not institution, give street and number)

Memorial Hospital

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

Funeral  
Director

5. Social Security Number

218-20-9735

6. Sex

M 2 ☒ F

7. Age (In yrs. last birthday)

68

8. Date of Birth (Month, Day, Year)

Dec. 3, 1927

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Queen Anne's

10c. City, Town or Location

Queenstown

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

113 Steamboat Avenue

10f. Zip Code

21658

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Trouble serviceman

16b. Kind of Business/Industry

Delmarva Power

17. Father's Name (First, Middle, Last)

Alvin Mills

18. Mother's Name (First, Middle, Maiden Surname)

Susie Brannock

19a. Informant's Name/Relationship (Type, Print)

Mrs. Sarah M. Mills

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

113 Steamboat Ave., P.O. Box 103 Queenstown Md. 21658

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Stevensville Cemetery

Date

Jan. 10, 1996

20c. Location - City or Town, State

Stevensville, Md.

21. Signature of Funeral Service Licensee

Chad N. Helfenbein

22. Name and Address of Facility

Tom Helfenbein Funeral Homes, P.A.  
106 Shamrock Rd., Chester, Md. 21619

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Cardiogenic Shock

Approximate interval Between Onset and Death

18 hours

Due to (or as a consequence of):

b. Congestive Heart Failure

60 days

Due to (or as a consequence of):

c. Acute Renal Failure

2 days

Due to (or as a consequence of):

d. Acute Hepatic Necrosis

1 day

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cor Pulmonale

Aortic Stenosis

COPD

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

26. Place of Death (Check only one)

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

MCS Rajasingh M.D., FACC

29c. License number

D41723

29d. Date signed (Month, Day, Year)

1/6/96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

M. Christadoss Rajasingh; 403 Marvel Ct.; Easton, Md. 21601

31. Date filed (Month, Day, Year)

JAN 16, 1996

32. Registrar's Signature

John S. ...

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04802

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Jerome Leroy Morton

2. Date of Death

Jan 25 1996

3. Time of Death

9:59 AM

4e. Facility Name (If not Institution, give street and number)

The Memorial Hospital at Easton

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

Funeral  
Director

5. Social Security Number

220-24-6678

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct. 4, 1928

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Queen Anne's

10c. City, Town or Location

Grasonville

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

130 Radcliffe Lane

10f. Zip Code

21638

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 195413. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Roll Supervisor

16b. Kind of Business/Industry

Steel Industry

17. Father's Name (First, Middle, Last)

Charles Morton

18. Mother's Name (First, Middle, Maiden Surname)

May Grief

19a. Informant's Name/Relationship (Type, Print)

Mrs. Anna Morton-Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

130 Radcliffe Lane, Grasonville, Md. 21638

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Md. Veteran's Cemetery

Date

Jan. 29, 1996

20c. Location - City or Town, State

Beulah, Md.

21. Signature of Funeral Service Licensee

Thomas K. Helfenbein

22. Name and Address of Facility

Tom Helfenbein Funeral Home, P.A.

106 Shamrock Rd., Chester, Md. 21619

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. CARDIAC ARREST

Due to (or as a consequence of):

b. Alcoholism

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

30 sec

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

GI bleeding

Anemia

Hypokalemia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Richard Burgoyne

29c. License number

042815

29d. Date signed (Month, Day, Year)

1/24/91

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Richard Burgoyne, MD. 607 Dutchman's Lane, Easton, Md. 21601

31. Date filed (Month, Day, Year)

01/26/96

32. Registrar's Signature

Daniel R. Riddle

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04803

|   |  |  |  |   |   |  |   |   |  |   |  |
|---|--|--|--|---|---|--|---|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>William Beuchert Martin   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>January 20, 1996  |   | 3. TIME OF DEATH<br>8:05 PM  |   |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br>220-26-2581  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>72 YRS.   |   | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>Feb. 4, 1923                               |   | 8. BIRTHPLACE (State or Foreign Country)<br>Washington, D.C.  |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Montgomery General Hospital   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Olney  |   |  | 9c. COUNTY OF DEATH<br>Montgomery   |   |  |   |  |
| 10a. STATE<br>Maryland  |  | 10b. COUNTY<br>Howard  |  | 10c. CITY, TOWN OR LOCATION<br>Woodbine   |   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |   |  |   |  |
| 10e. STREET AND NUMBER<br>3268 Woodbine Road  |  |  |  | 10f. ZIP CODE<br>21797  |   | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   |   |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                                    |   |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Farmer  |  |   | 16b. KIND OF BUSINESS/INDUSTRY<br>Dairy |  |   |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Oscar C. Martin  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Barbara Beuchert   |   |  |   |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Paul B. Martin  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>17541 Timberleigh Way, Woodbine, Maryland 21797  |   |  |   |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Salem Cemetery  |  | DATE<br>1/24  |   | 20c. LOCATION — City or Town, State<br>Brookeville, Maryland                         |   |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Olin L. Molesworth   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Olin L. Molesworth, P.A., Funeral Home<br>26401 Ridge Road, Damascus, Maryland 20872  |   |  |   |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SUBDURAL HEMATOMA<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |   |  |   | Approximate interval Between Onset and Death<br>4 weeks   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>ANTICOAGULANT THERAPY   |  |  |  |   |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  |   |   |  |   |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |   |  |   |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide<br>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |   | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
|   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |   | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)         |   |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>29b. SIGNATURE AND TITLE OF CERTIFIER<br>29c. LICENSE NUMBER<br>29d. DATE SIGNED (Month, Day, Year)<br>January 22, 1996                               |  |  |  |   |   |  |   |   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Edwin Johnson MD 3416 OLANDWOOD COURT, OLNEY, MD 20834   |  |  |  |   |   |  |   |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>JAN 24 1996  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>Audrey Randall   |   |  |   |   |  |   |  |

2011

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR   |  |   |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 96 04804   |  |   |  |
|--|--|---|--|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)   |  |   |  | 2. DATE OF DEATH   |  |   |  | 3. TIME OF DEATH   |  |   |  |
| JOHN PAUL MAHER  |  |   |  | Jan. 20, 1996  |  |   |  | 12:00 P.M.   |  |   |  |
| 4. SOCIAL SECURITY NUMBER  |  | 5. SEX  |  | 6. AGE (In yrs. last birthday)   |  | 7. DATE OF BIRTH  |  | 8. BIRTHPLACE (State or Foreign Country)                     |  |   |  |
| 087-18-9222  |  | 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F            |  | 75 YRS.  |  | Oct. 25, 1920   |  | South Carolina   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH  |  |   |  | 9c. COUNTY OF DEATH  |  |   |  |
| 403 North Market Street  |  |   |  | Frederick  |  |   |  | Frederick  |  |   |  |
| RESIDENCE OF DECEDENT  |  |   |  |  |  |   |  |  |  |   |  |
| 10a. STATE   |  | 10b. COUNTY   |  | 10c. CITY, TOWN OR LOCATION  |  | 10d. INSIDE CITY LIMITS?  |  |  |  |   |  |
| Maryland   |  | Frederick   |  | Frederick  |  | 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |  |  |   |  |
| 10e. STREET AND NUMBER   |  |   |  | 10f. ZIP CODE  |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?                                |  |   |  |
| 403 North Market Street  |  |   |  | 21701  |  |   |  | U.S.A.   |  |   |  |
| 11. MARITAL STATUS   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?                                     |  | 13. WAS DECEDENT OF HISPANIC ORIGIN?   |  | 14. RACE — American Indian, Black, White, etc.                          |  |  |  |   |  |
| 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married   |  | 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO         |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | Specify: White  |  |  |  |   |  |
| 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | IF YES, GIVE WAR OR DATES<br>WWII   |  | Specify:   |  |   |  |  |  |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)  |  |   |  | 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)   |  |   |  | 18b. KIND OF BUSINESS/INDUSTRY                               |  |   |  |
| Elementary/Secondary (0-12) 7  |  |   |  | Advertising Specialist   |  |   |  | None   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)  |  |   |  |  |  |   |  |
| Paul Patrick Maher   |  |   |  | Grace Bohn   |  |   |  |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)  |  |   |  |  |  |   |  |
| Christopher J. Maher   |  |   |  | 321 North Market Street, Frederick, Maryland 21701   |  |   |  |  |  |   |  |
| 20a. METHOD OF DISPOSITION   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) |  | DATE   |  | 20c. LOCATION — City or Town, State                                     |  |  |  |   |  |
| 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State  |  | Smithsburg Crematory  |  | 1/24   |  | Smithsburg, Maryland  |  |  |  |   |  |
| 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |   |  |  |  |   |  |  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  |  |   |  | 22. NAME AND ADDRESS OF FACILITY   |  |   |  |  |  |   |  |
|  |  |   |  | ROBERT E. DAILEY & SON FUNERAL HOMES, P.A.<br>1201 NORTH MARKET ST., Frederick, MD 21701   |  |   |  |  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |  |  |   |  | Approximate Interval Between Onset and Death                 |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  |   |  |  |  |   |  | 10yrs  |  |   |  |
| a. A.S.H.D.  |  |   |  |  |  |   |  |  |  |   |  |
| b. (In) HYPERTENSION C.H.F.  |  |   |  |  |  |   |  | 15yrs  |  |   |  |
| c. HYPERTENSION  |  |   |  |  |  |   |  | 20yrs  |  |   |  |
| d.   |  |   |  |  |  |   |  |  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?                               |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |  |
| C.H.F.   |  |   |  |  |  |   |  | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |   |  |  |  |   |  |  |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?   |  |   |  | 26. PLACE OF DEATH (Check only one)  |  |   |  |  |  |   |  |
| 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |   |  | HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |   |  |
| 27. MANNER OF DEATH  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY  |  | 28c. INJURY AT WORK?  |  | 28d. DESCRIBE HOW INJURY OCCURRED                            |  |   |  |
| 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |  |   |  | M  |  | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO            |  |  |  |   |  |
| 29a. CERTIFIER (Check only one)  |  |   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER  |  |   |  | 29c. LICENSE NUMBER  |  | 29d. DATE SIGNED (Month, Day, Year)   |  |
| 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |  |  |   |  | D-31912  |  | 1/22/96   |  |
| 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |  |  |   |  |  |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  |  |   |  |  |  |   |  |  |  |   |  |
| Julio Menocal, MD 1564 Opossumtown Pike, Frederick, Maryland 21701   |  |   |  |  |  |   |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)  |  |   |  | 32. REGISTRAR'S SIGNATURE  |  |   |  |  |  |   |  |
| JAN 24 1996  |  |   |  |  |  |   |  |  |  |   |  |

3022



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 96 04805

Physician  
(Medical  
Examiner)

1. Decedent's Name (First, Middle, Last)

FENTON RICKARD MILLER

2. Date of Death  
Month Day Year  
JANUARY 29, 19963. Time of Death  
10:59 a.m.Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

008-09-2469

6. Sex

1 ☒ M 2 ☐ F

7. Age (in yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

August 2, 1913

9. Birthplace (State or Foreign Country)

Vermont

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

10e. Street and Number

4833 Mt. Zion Rd.

10f. Zip Code

21703

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Experimental Engineer

16b. Kind of Business/Industry

Aircraft Motor/Jets

17. Father's Name (First, Middle, Last)

Berton Henry Miller

18. Mother's Name (First, Middle, Maiden Surname)

Cora Marcella Rickard

19a. Informant's Name/Relationship (Type, Print)

Theodore Miller

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4833 Mt. Zion Rd., Frederick, MD 21703

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Grove Cemetery

Date

2/1/96

20c. Location - City or Town, State

New London, Connecticut

21. Signature of Funeral Service Licensee



22. Name and Address of Facility Stauffer Funeral Home

1621 Opossumtown Pike, Frederick, MD 21702

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. acute myocardial Infarction

Approximate Interval Between Onset and Death

5 days.

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D 21648

29d. Date signed (Month, Day, Year)

1/29/96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Kusay BARAKAT 310 W 9th Street Frederick MD 21701

31. Date filed (Month, Day, Year)

FEB 02 1996

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR   |  |   |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 96 04806  |  |                                   |  |
|--|--|---|--|--|--|---|--|---|--|-----------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)   |  |   |  | 2. DATE OF DEATH   |  |   |  | 3. TIME OF DEATH  |  |                                   |  |
| JAMES DIETRICH MILLER JR.  |  |   |  | MONTH 1 DAY 31 YEAR 96   |  |   |  | 1817 M  |  |                                   |  |
| 4. SOCIAL SECURITY NUMBER  |  | 5. SEX  |  | 6. AGE (In yrs. last birthday)   |  | 7. DATE OF BIRTH  |  | 8. BIRTHPLACE (State or Foreign Country)  |  |                                   |  |
| 378-42-6695  |  | 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F    |  | 53 YRS.  |  | MONTHS DAYS HOURS MIN.  |  | 11/3/42   |  | PA                                |  |
| 9a. FACILITY NAME (If not institution, give street and number)   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH  |  |   |  | 9c. COUNTY OF DEATH   |  |                                   |  |
| Anne Arundel Hospital  |  |   |  | Annapolis  |  |   |  | Anne Arundel  |  |                                   |  |
| RESIDENCE OF DECEDENT  |  |   |  |  |  |   |  |   |  |                                   |  |
| 10a. STATE   |  | 10b. COUNTY   |  | 10c. CITY, TOWN OR LOCATION  |  |   |  | 10d. INSIDE CITY LIMITS?  |  |                                   |  |
| MD   |  | Worcester   |  | Berlin   |  |   |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO           |  |                                   |  |
| 10e. STREET AND NUMBER   |  |   |  | 10f. ZIP CODE  |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?   |  |                                   |  |
| 12545 River Run Lane #67   |  |   |  | 21811  |  |   |  | USA   |  |                                   |  |
| 11. MARITAL STATUS   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?                             |  | 13. WAS DECEDENT OF HISPANIC ORIGIN?   |  | 14. RACE — American Indian, Black, White, etc.  |  |   |  |                                   |  |
| 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married   |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | Specify: white  |  |   |  |                                   |  |
| 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | IF YES, GIVE WAR OR DATES   |  | Specify:   |  |   |  |   |  |                                   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)  |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)   |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |                                   |  |
| Elementary/Secondary (0-12) College (1-4 or 5+)  |  |   |  | Management Executive   |  |   |  | Communications  |  |                                   |  |
| 4  |  |   |  |  |  |   |  |   |  |                                   |  |
| 17. FATHER'S NAME (First, Middle, Last)  |  |   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)   |  |   |  |                                   |  |
| James Dietrich Miller, Sr.   |  |   |  |  |  | Genevieve Mahon   |  |   |  |                                   |  |
| 19a. INFORMANT'S NAME (Type/Print)   |  |   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |  |   |  |                                   |  |
| Mary Beth Miller   |  |   |  |  |  | 12545 River Run Lane #67 Berlin, MD 21811   |  |   |  |                                   |  |
| 20a. METHOD OF DISPOSITION   |  |   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)  |  | DATE  |  | 20c. LOCATION — City or Town, State   |  |                                   |  |
| 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State  |  |   |  | Sunset Memorial Park   |  | 2/5/96  |  | Berlin, MD  |  |                                   |  |
| 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |   |  |  |  |   |  |   |  |                                   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  |  |   |  |  |  | 22. NAME AND ADDRESS OF FACILITY  |  |   |  |                                   |  |
|    |  |   |  |  |  | Burbage Funeral Home<br>108 Williams St. Berlin, MD 21811                                     |  |   |  |                                   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |  |  |   |  |   |  |                                   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive heart failure  |  |   |  |  |  |   |  |   |  |                                   |  |
| b. Coronary artery disease   |  |   |  |  |  |   |  |   |  |                                   |  |
| Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  |   |  |  |  |   |  |   |  |                                   |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |  |  |   |  |   |  |                                   |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |  |  |   |  |   |  |                                   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  |   |  |   |  |                                   |  |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |   |  |  |  |   |  |   |  |                                   |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |   |  |  |  |   |  |   |  |                                   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |   |  |  |  |   |  |   |  |                                   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |   |  | 26. PLACE OF DEATH (Check only one)  |  |   |  |   |  |                                   |  |
|  |  |   |  | HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |                                   |  |
| 27. MANNER OF DEATH  |  |   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY   |  | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED |  |
| 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  |   |  |  |  | M   |  |   |  |                                   |  |
|  |  |   |  | 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)      |  |                                   |  |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |  |  |   |  |   |  |                                   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  |  |   |  |  |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)   |  |                                   |  |
|   |  |   |  |  |  | 11615   |  | 2/1/96  |  |                                   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  |  |   |  |  |  |   |  |   |  |                                   |  |
| Richard J. Katz MD 2150 Pennsylvania Ave. NW Washington, DC  |  |   |  |  |  |   |  |   |  |                                   |  |
| 31. DATE FILED (Month, Day, Year)  |  |   |  | 32. REGISTRAR'S SIGNATURE  |  |   |  |   |  |                                   |  |
| FEB 05 1996  |  |   |  |   |  |   |  |   |  |                                   |  |



TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR  |  |   |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 96 04807   |  |                                     |  |
|---|--|---|--|--|--|--|--|--|--|-------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)  |  |   |  | 2. DATE OF DEATH   |  |  |  | 3. TIME OF DEATH   |  |                                     |  |
| LOREN FRANCIS NICOL   |  |   |  | January 22, 1996   |  |  |  | 12:30 A. M   |  |                                     |  |
| 4. SOCIAL SECURITY NUMBER   |  | 5. SEX  |  | 6. AGE (In yrs. last birthday)   |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS.   |  | 7. DATE OF BIRTH                    |  |
| 347-14-9440   |  | XX M 2 F  |  | 75 YRS.  |  | MONTHS DAYS  |  | HOURS MIN.   |  | Feb. 11, 1920                       |  |
| 9a. FACILITY NAME (If not institution, give street and number)  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH  |  |  |  | 9c. COUNTY OF DEATH  |  |                                     |  |
| Meridian Healthcare   |  |   |  | Frederick  |  |  |  | Frederick  |  |                                     |  |
| RESIDENCE OF DECEDENT   |  |   |  | 10c. CITY, TOWN OR LOCATION  |  |  |  | 10d. INSIDE CITY LIMITS?   |  |                                     |  |
| 19a. STATE  |  |   |  | 10b. COUNTY  |  | Mt. Airy   |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO      |  |                                     |  |
| Maryland  |  |   |  | Frederick  |  |  |  |  |  |                                     |  |
| 10e. STREET AND NUMBER  |  |   |  | 10f. ZIP CODE  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?  |  |                                     |  |
| 13951 Penn Shop Road  |  |   |  | 21771  |  |  |  | United States  |  |                                     |  |
| 11. MARITAL STATUS  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN?   |  | 14. RACE — American Indian, Black, White, etc.               |  |  |  |                                     |  |
| 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married  |  | 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                    |  | Specify: White   |  |  |  |                                     |  |
| 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | IF YES, GIVE YEAR OR DATES  |  |  |  |  |  |  |  |                                     |  |
|   |  | 1940-1962   |  |  |  |  |  |  |  |                                     |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)   |  |   |  | 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |                                     |  |
| Elementary/Secondary (0-12)   |  |   |  | College (1-4 or 5+)  |  |  |  | U.S. Army  |  |                                     |  |
| 12  |  |   |  |  |  |  |  | Military   |  |                                     |  |
| 17. FATHER'S NAME (First, Middle, Last)   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)  |  |  |  |  |  |                                     |  |
| Clyde Nicol   |  |   |  | Mamie Nagel  |  |  |  |  |  |                                     |  |
| 19a. INFORMANT'S NAME (Type/Print)  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)              |  |  |  |  |  |                                     |  |
| Rosemary Maynard  |  |   |  | 6600 Jacks Court Mt. Airy, Maryland 21771  |  |  |  |  |  |                                     |  |
| 20a. METHOD OF DISPOSITION  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)   |  | DATE   |  | 20c. LOCATION — City or Town, State                          |  |  |  |                                     |  |
| 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State   |  | Hagerstown Crematory  |  | 1/25/96  |  | Hagerstown, Maryland   |  |  |  |                                     |  |
| 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |   |  |  |  |  |  |  |  |                                     |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE   |  |   |  | 22. NAME AND ADDRESS OF FACILITY   |  |  |  |  |  |                                     |  |
|   |  |   |  | Stauffer Funeral Home, Inc.  |  |  |  |  |  |                                     |  |
|   |  |   |  | 8 E. Ridgeville Blvd. Mt. Airy, MD 21771   |  |  |  |  |  |                                     |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. |  |   |  |  |  |  |  | Approximate Interval Between Onset and Death                                 |  |                                     |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →   |  |   |  |  |  |  |  | 1 DAY  |  |                                     |  |
| a. ASPIRATION PNEUMONIA   |  |   |  |  |  |  |  |  |  |                                     |  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |  |  |  |  |  |  |                                     |  |
| b. PARKINSONS DISEASE   |  |   |  |  |  |  |  | 20 YEARS   |  |                                     |  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |  |  |  |  |  |  |                                     |  |
| c.  |  |   |  |  |  |  |  |  |  |                                     |  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |  |  |  |  |  |  |                                     |  |
| d.  |  |   |  |  |  |  |  |  |  |                                     |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  |  |   |  |  |  |  |  |  |  |                                     |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?   |  |                                     |  |
| DEMENTIA  |  |   |  |  |  |  |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO      |  |                                     |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?   |  |   |  |  |  |  |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO      |  |                                     |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>   |  |   |  |  |  |  |  |  |  |                                     |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?  |  | 26. PLACE OF DEATH (Check only one)   |  |  |  |  |  |  |  |                                     |  |
| 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA                    |  |  |  |  |  |  |  |                                     |  |
|   |  | OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |  |  |                                     |  |
| 27. MANNER OF DEATH   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY  |  | 28c. INJURY AT WORK?   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |                                     |  |
| 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation  |  |   |  | M  |  | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |  |  |                                     |  |
| 2 <input type="checkbox"/> Accident   |  |   |  |  |  |  |  |  |  |                                     |  |
| 3 <input type="checkbox"/> Suicide  |  |   |  |  |  |  |  |  |  |                                     |  |
| 4 <input type="checkbox"/> Homicide   |  |   |  |  |  |  |  |  |  |                                     |  |
|   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |  |                                     |  |
|   |  |   |  |  |  |  |  |  |  |                                     |  |
| 29a. CERTIFIER (Check only one)   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER   |  |  |  |  |  | 29c. LICENSE NUMBER  |  | 29d. DATE SIGNED (Month, Day, Year) |  |
| 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                        |  |   |  |  |  |  |  | D43091   |  | 1-22-96                             |  |
| 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  |  |  |  |  |  |                                     |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)   |  |   |  |  |  |  |  |  |  |                                     |  |
| Dr. Saeed Zaidi 801 Tollhouse Avenue, Frederick, MD 21701   |  |   |  |  |  |  |  |  |  |                                     |  |
| 31. DATE FILED (Month, Day, Year)   |  |   |  |  |  |  |  |  |  |                                     |  |
| JAN 24 1996   |  |   |  |  |  |  |  |  |  |                                     |  |
| 32. REGISTRAR'S SIGNATURE   |  |   |  |  |  |  |  |  |  |                                     |  |
|   |  |   |  |  |  |  |  |  |  |                                     |  |

FORM 20

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR  |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 96 04808  |  |  |  |
|--|--|--|--|---|--|--|--|---|--|--|--|
| CERTIFICATE OF DEATH   |  |  |  | REG. NO.  |  |  |  |   |  |  |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Charles Everett O'Donnell  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>Jan. 11, 1996   |  |  |  | 3. TIME OF DEATH<br>M   |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br>212-12-9658   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>86 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>Mar. 16, 1909                                 |  | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>113 Church Lane  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Grasonville  |  |  |  | 9c. COUNTY OF DEATH<br>Queen Anne's   |  |  |  |
| 10a. STATE<br>Maryland   |  |  |  | 10b. COUNTY<br>Queen Anne's   |  | 10c. CITY, TOWN OR LOCATION<br>Grasonville   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO       |  |  |  |
| 10e. STREET AND NUMBER<br>113 Church Lane  |  |  |  | 10f. ZIP CODE<br>21638  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |   |  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                     |  |   |  |  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 6<br>College (1-4 or 5+)  |  | 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Painter, Waterman  |  | 18b. KIND OF BUSINESS/INDUSTRY<br>Self  |  |  |  |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Omer O'Donnell  |  |  |  | 16. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Esther Elizabeth Pratt   |  |  |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>John & Freda Thomas  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>109 Church Lane, Grasonville, Md. 21638  |  |  |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Woodlawn Cemetery Jan. 15, 1996   |  | 20c. LOCATION — City or Town, State<br>Easton, Md.  |  |  |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Chad M. Helfenbein  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Tom Helfenbein Funeral Homes, P.A.<br>106 Shamrock Rd., Chester, Md.  |  |  |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiovascular Disease<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |  |  | Approximate Interval Between Onset and Death<br>Remote  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Carcinoma of Prostate<br>Diabetes<br>Hypertension<br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Ralph Libby   |  |  |  |   |  | 29c. LICENSE NUMBER<br>D057541   |  | 29d. DATE SIGNED (Month, Day, Year)<br>1-11-96  |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Type, Print)<br>Ralph Libby; 204 Medical Center Rd., Grasonville, Md. 21638   |  |  |  |   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>JAN 16 1996   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>John S. Anderson-Randall   |  |  |  |   |  |  |  |

30810 20

Amended Lines 10e and 19b JLD, FCHD as Per Funeral Director  
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

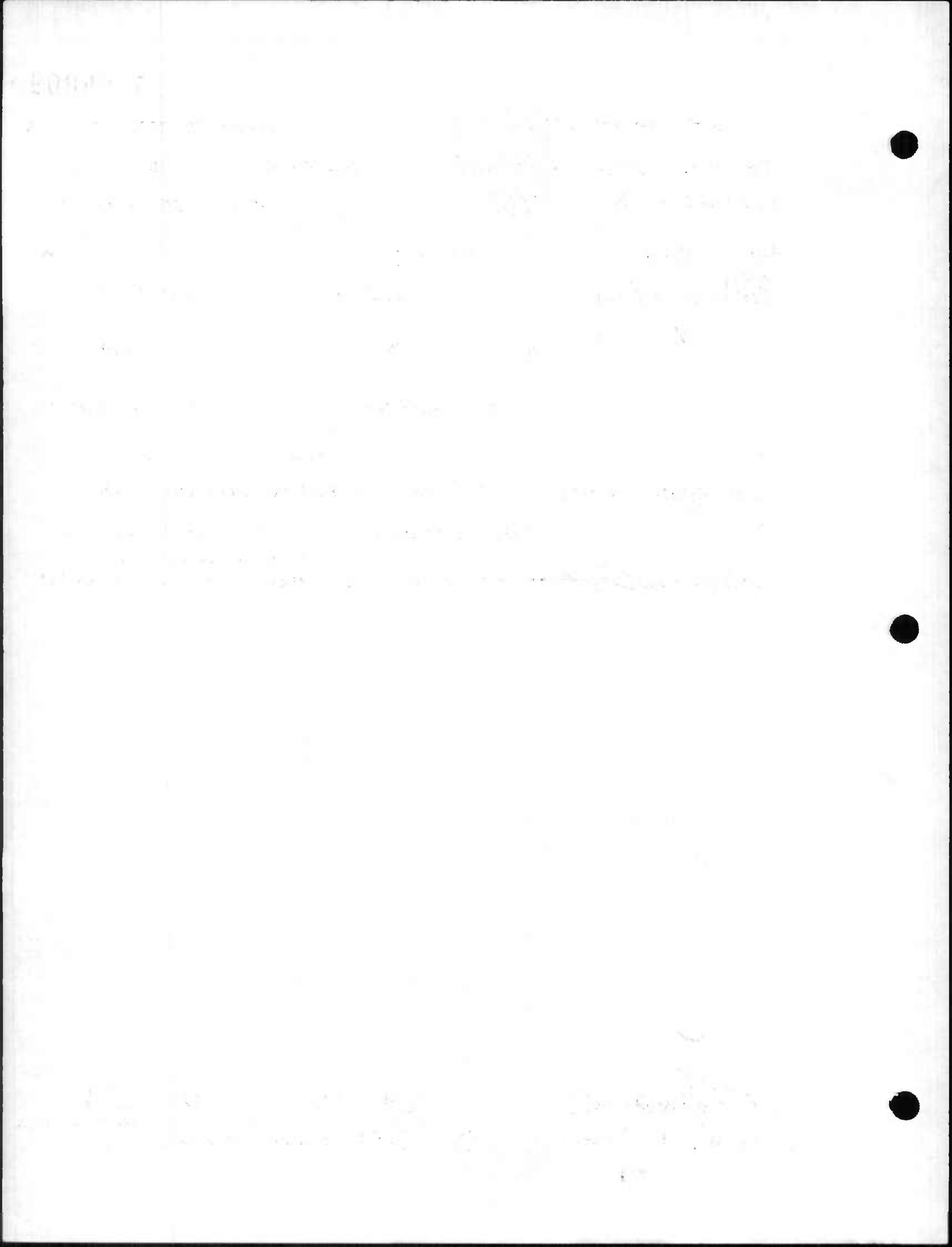
Certificate of Death

Reg. No. 96 04809

|                                     |   |  |   |   |   |  |  |  |
|-------------------------------------|---|--|---|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>David Bernard Offutt  |  |   |   | 2. Date of Death<br>Month Day Year<br>January 29 1996   |  | 3. Time of Death<br>7:25 A                                       |  |
|                                     | 4a. Facility Name (If not institution, give street and number)<br>Frederick Memorial Hospital   |  |   |   | 4b. City, Town, or Location of Death<br>Frederick   |  | 4c. County of Death<br>Frederick                                 |  |
| Funeral<br>Director                 | 5. Social Security Number<br>219-12-1315  |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>75 Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.                             | 8. Date of Birth<br>(Month, Day, Year)<br>11/03/20               | 9. Birthplace (State or Foreign Country)<br>Maryland   |
|                                     | Usual Residence of Decedent   |  |   |   |   |  |  |  |
| To Be Completed by Funeral Director | 10a. State<br>Md.   |  | 10b. County<br>Fred.  |   | 10c. City, Town or Location<br>Frederick  |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
|                                     | 10e. Street and Number<br>3411 Tobery Road  |  |   |   | 10f. Zip Code<br>21704  |  | 10g. Citizen of What Country?<br>United States                   |  |
|                                     | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: Korea |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: Black |  |
|                                     | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) -  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>Transportation                              |   |   | 16b. Kind of Business/Industry<br>Federal government       |  |  |
|                                     | 17. Father's Name (First, Middle, Last)   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Bertha Fisher  |  |  |  |
|                                     | 19a. Informant's Name/Relationship (Type, Print)<br>Frances Melviena Offutt   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3411 Tobery Rd./ Frederick, Maryland 21704   |  |  |  |
|                                     | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Fairview Cemetery   |   | Date<br>2-3-96  | 20c. Location - City or Town, State<br>Frederick, Maryland |  |  |
|                                     | 21. Signature of Funeral Service Licensee<br><i>Raymond Peterson</i>  |  |   |   | 22. Name and Address of Facility<br>Stauffer Funeral Home<br>1621 Opossumtown Pike/ Frederick, Maryland 21702   |  |  |  |
|                                     | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <u>Electrolyte Disturbance Hyperkalemia</u> Immediate<br>Due to (or as a consequence of):<br>b. <u>End Stage Renal Disease - Off Dialysis</u> 1 week<br>(Discontinued)<br>Due to (or as a consequence of):<br>c. <u>Hypertension</u><br>Due to (or as a consequence of):<br>d.<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>e.<br>f.<br>g.<br>h.<br>i.<br>j.<br>k.<br>l.<br>m.<br>n.<br>o.<br>p.<br>q.<br>r.<br>s.<br>t.<br>u.<br>v.<br>w.<br>x.<br>y.<br>z.<br>aa.<br>ab.<br>ac.<br>ad.<br>ae.<br>af.<br>ag.<br>ah.<br>ai.<br>aj.<br>ak.<br>al.<br>am.<br>an.<br>ao.<br>ap.<br>aq.<br>ar.<br>as.<br>at.<br>au.<br>av.<br>aw.<br>ax.<br>ay.<br>az.<br>ba.<br>bb.<br>bc.<br>bd.<br>be.<br>bf.<br>bg.<br>bh.<br>bi.<br>bj.<br>bk.<br>bl.<br>bm.<br>bn.<br>bo.<br>bp.<br>bq.<br>br.<br>bs.<br>bt.<br>bu.<br>bv.<br>bw.<br>bx.<br>by.<br>bz.<br>ca.<br>cb.<br>cc.<br>cd.<br>ce.<br>cf.<br>cg.<br>ch.<br>ci.<br>cj.<br>ck.<br>cl.<br>cm.<br>cn.<br>co.<br>cp.<br>cq.<br>cr.<br>cs.<br>ct.<br>cu.<br>cv.<br>cw.<br>cx.<br>cy.<br>cz.<br>da.<br>db.<br>dc.<br>dd.<br>de.<br>df.<br>dg.<br>dh.<br>di.<br>dj.<br>dk.<br>dl.<br>dm.<br>dn.<br>do.<br>dp.<br>dq.<br>dr.<br>ds.<br>dt.<br>du.<br>dv.<br>dw.<br>dx.<br>dy.<br>dz.<br>ea.<br>eb.<br>ec.<br>ed.<br>ee.<br>ef.<br>eg.<br>eh.<br>ei.<br>ej.<br>ek.<br>el.<br>em.<br>en.<br>eo.<br>ep.<br>eq.<br>er.<br>es.<br>et.<br>eu.<br>ev.<br>ew.<br>ex.<br>ey.<br>ez.<br>fa.<br>fb.<br>fc.<br>fd.<br>fe.<br>ff.<br>fg.<br>fh.<br>fi.<br>fj.<br>fk.<br>fl.<br>fm.<br>fn.<br>fo.<br>fp.<br>fq.<br>fr.<br>fs.<br>ft.<br>fu.<br>fv.<br>fw.<br>fx.<br>fy.<br>fz.<br>ga.<br>gb.<br>gc.<br>gd.<br>ge.<br>gf.<br>gg.<br>gh.<br>gi.<br>gj.<br>gk.<br>gl.<br>gm.<br>gn.<br>go.<br>gp.<br>gq.<br>gr.<br>gs.<br>gt.<br>gu.<br>gv.<br>gw.<br>gx.<br>gy.<br>gz.<br>ha.<br>hb.<br>hc.<br>hd.<br>he.<br>hf.<br>hg.<br>hh.<br>hi.<br>hj.<br>hk.<br>hl.<br>hm.<br>hn.<br>ho.<br>hp.<br>hq.<br>hr.<br>hs.<br>ht.<br>hu.<br>hv.<br>hw.<br>hx.<br>hy.<br>hz.<br>ia.<br>ib.<br>ic.<br>id.<br>ie.<br>if.<br>ig.<br>ih.<br>ii.<br>ij.<br>ik.<br>il.<br>im.<br>in.<br>io.<br>ip.<br>iq.<br>ir.<br>is.<br>it.<br>iu.<br>iv.<br>iw.<br>ix.<br>iy.<br>iz.<br>ja.<br>jb.<br>jc.<br>jd.<br>je.<br>jf.<br>jg.<br>jh.<br>ji.<br>jj.<br>jk.<br>jl.<br>jm.<br>jn.<br>jo.<br>jp.<br>jq.<br>jr.<br>js.<br>jt.<br>ju.<br>jv.<br>jw.<br>jx.<br>jy.<br>jz.<br>ka.<br>kb.<br>kc.<br>kd.<br>ke.<br>kf.<br>kg.<br>kh.<br>ki.<br>kj.<br>kk.<br>kl.<br>km.<br>kn.<br>ko.<br>kp.<br>kq.<br>kr.<br>ks.<br>kt.<br>ku.<br>kv.<br>kw.<br>kx.<br>ky.<br>kz.<br>la.<br>lb.<br>lc.<br>ld.<br>le.<br>lf.<br>lg.<br>lh.<br>li.<br>lj.<br>lk.<br>ll.<br>lm.<br>ln.<br>lo.<br>lp.<br>lq.<br>lr.<br>ls.<br>lt.<br>lu.<br>lv.<br>lw.<br>lx.<br>ly.<br>lz.<br>ma.<br>mb.<br>mc.<br>md.<br>me.<br>mf.<br>mg.<br>mh.<br>mi.<br>mj.<br>mk.<br>ml.<br>mm.<br>mn.<br>mo.<br>mp.<br>mq.<br>mr.<br>ms.<br>mt.<br>mu.<br>mv.<br>mw.<br>mx.<br>my.<br>mz.<br>na.<br>nb.<br>nc.<br>nd.<br>ne.<br>nf.<br>ng.<br>nh.<br>ni.<br>nj.<br>nk.<br>nl.<br>nm.<br>nn.<br>no.<br>np.<br>nq.<br>nr.<br>ns.<br>nt.<br>nu.<br>nv.<br>nw.<br>nx.<br>ny.<br>nz.<br>oa.<br>ob.<br>oc.<br>od.<br>oe.<br>of.<br>og.<br>oh.<br>oi.<br>oj.<br>ok.<br>ol.<br>om.<br>on.<br>oo.<br>op.<br>oq.<br>or.<br>os.<br>ot.<br>ou.<br>ov.<br>ow.<br>ox.<br>oy.<br>oz.<br>pa.<br>pb.<br>pc.<br>pd.<br>pe.<br>pf.<br>pg.<br>ph.<br>pi.<br>pj.<br>pk.<br>pl.<br>pm.<br>pn.<br>po.<br>pp.<br>pq.<br>pr.<br>ps.<br>pt.<br>pu.<br>pv.<br>pw.<br>px.<br>py.<br>pz.<br>qa.<br>qb.<br>qc.<br>qd.<br>qe.<br>qf.<br>qg.<br>qh.<br>qi.<br>qj.<br>qk.<br>ql.<br>qm.<br>qn.<br>qo.<br>qp.<br>qq.<br>qr.<br>qs.<br>qt.<br>qu.<br>qv.<br>qw.<br>qx.<br>qy.<br>qz.<br>ra.<br>rb.<br>rc.<br>rd.<br>re.<br>rf.<br>rg.<br>rh.<br>ri.<br>rj.<br>rk.<br>rl.<br>rm.<br>rn.<br>ro.<br>rp.<br>rq.<br>rr.<br>rs.<br>rt.<br>ru.<br>rv.<br>rw.<br>rx.<br>ry.<br>rz.<br>sa.<br>sb.<br>sc.<br>sd.<br>se.<br>sf.<br>sg.<br>sh.<br>si.<br>sj.<br>sk.<br>sl.<br>sm.<br>sn.<br>so.<br>sp.<br>sq.<br>sr.<br>ss.<br>st.<br>su.<br>sv.<br>sw.<br>sx.<br>sy.<br>sz.<br>ta.<br>tb.<br>tc.<br>td.<br>te.<br>tf.<br>tg.<br>th.<br>ti.<br>tj.<br>tk.<br>tl.<br>tm.<br>tn.<br>to.<br>tp.<br>tq.<br>tr.<br>ts.<br>tu.<br>tv.<br>tw.<br>tx.<br>ty.<br>tz.<br>ua.<br>ub.<br>uc.<br>ud.<br>ue.<br>uf.<br>ug.<br>uh.<br>ui.<br>uj.<br>uk.<br>ul.<br>um.<br>un.<br>uo.<br>up.<br>uq.<br>ur.<br>us.<br>ut.<br>uu.<br>uv.<br>uw.<br>ux.<br>uy.<br>uz.<br>va.<br>vb.<br>vc.<br>vd.<br>ve.<br>vf.<br>vg.<br>vh.<br>vi.<br>vj.<br>vk.<br>vl.<br>vm.<br>vn.<br>vo.<br>vp.<br>vq.<br>vr.<br>vs.<br>vt.<br>vu.<br>vv.<br>vw.<br>vx.<br>vy.<br>vz.<br>wa.<br>wb.<br>wc.<br>wd.<br>we.<br>wf.<br>wg.<br>wh.<br>wi.<br>wj.<br>wk.<br>wl.<br>wm.<br>wn.<br>wo.<br>wp.<br>wq.<br>wr.<br>ws.<br>wt.<br>wu.<br>wv.<br>ww.<br>wx.<br>wy.<br>wz.<br>xa.<br>xb.<br>xc.<br>xd.<br>xe.<br>xf.<br>xg.<br>xh.<br>xi.<br>xj.<br>xk.<br>xl.<br>xm.<br>xn.<br>xo.<br>xp.<br>xq.<br>xr.<br>xs.<br>xt.<br>xu.<br>xv.<br>xw.<br>xx.<br>xy.<br>xz.<br>ya.<br>yb.<br>yc.<br>yd.<br>ye.<br>yf.<br>yg.<br>yh.<br>yi.<br>yj.<br>yk.<br>yl.<br>ym.<br>yn.<br>yo.<br>yp.<br>yq.<br>yr.<br>ys.<br>yt.<br>yu.<br>yv.<br>yw.<br>yx.<br>yy.<br>yz.<br>za.<br>zb.<br>zc.<br>zd.<br>ze.<br>zf.<br>zg.<br>zh.<br>zi.<br>zj.<br>zk.<br>zl.<br>zm.<br>zn.<br>zo.<br>zp.<br>zq.<br>zr.<br>zs.<br>zt.<br>zu.<br>zv.<br>zw.<br>zx.<br>zy.<br>zz. |  |   |   |   |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR   |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 96 04810  |  |   |  |   |  |  |  |
|---|--|--|--|--|--|--|--|---|--|---|--|---|--|--|--|
| CERTIFICATE OF DEATH  |  |  |  | REG. NO.   |  |  |  |   |  |   |  |   |  |  |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Kathryn Frances ORMOND</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>January</b> DAY <b>26</b> , YEAR <b>1996</b>  |  |  |  | 3. TIME OF DEATH<br><b>12:25 PM</b>   |  |   |  |   |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>196-26-6359</b>   |  | 5. SEX<br><b>1</b> <input type="checkbox"/> M <b>2</b> <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>82</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b> |  | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b>  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>July 2, 1913</b> |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Pennsylvania</b>   |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>6621 Struttman Lane</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Rockville</b>  |  |  |  | 9c. COUNTY OF DEATH<br><b>Montgomery</b>  |  |   |  |   |  |  |  |
| RESIDENCE OF DECEDENT   |  |  |  |  |  |  |  |   |  |   |  |   |  |  |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Montgomery</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Rockville</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO |  |   |  |   |  |  |  |
| 10e. STREET AND NUMBER<br><b>6621 Struttman Lane</b>  |  |  |  | 10f. ZIP CODE<br><b>20852</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  |   |  |  |  |
| 11. MARITAL STATUS<br><b>3</b> <input checked="" type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify:  |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |   |  |   |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>6</b> Elementary/Secondary (9-12) <b>College (1-4 or 5 +)</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Own Home</b>   |  |   |  |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Joseph DEENEY</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Sarah ROACH</b>  |  |  |  |   |  |   |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mrs. Barbara A. Rock</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6621 Struttman Lane, Rockville, Maryland 20852</b>   |  |  |  |   |  |   |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><b>1</b> <input type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State<br><b>4</b> <input type="checkbox"/> Donation <b>5</b> <input checked="" type="checkbox"/> Other (Specify) <b>Entombment</b>  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Resthaven Memorial Gardens, Feb. 3, 1996 Frederick, Maryland</b>   |  |  |  | 20c. LOCATION — City or Town, State   |  |   |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Richard E. Huff</b> MOO255  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Keeney and Basford P.A. Funeral Home<br/>106 East Church St., Frederick, Md. 21701</b>  |  |  |  |   |  |   |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Emphysema</b><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>Hypertension</b><br><b>Lung cancer</b> |  |  |  |  |  |  |  |   |  |   |  | Approximate Interval Between Onset and Death<br><b>&gt;5YRS</b><br><b>2YRS</b><br><b>1YR</b>                            |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |  |  |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/> <b>UNCERTAIN</b> <input type="checkbox"/>   |  |  |  |  |  |  |  |   |  |   |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO   |  |  |  | 28. PLACE OF DEATH (Check only one)<br>HOSPITAL: <b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA<br>OTHER: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input checked="" type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify) |  |  |  |   |  |   |  |   |  |  |  |
| 27. MANNER OF DEATH<br><b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending investigation<br><b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined<br><b>3</b> <input type="checkbox"/> Suicide <b>8</b> <input type="checkbox"/> Homicide   |  |  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>                  |  | 28c. INJURY AT WORK?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO                |  | 28d. DESCRIBE HOW INJURY OCCURRED                             |  |   |  |  |  |
|   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, tectory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                      |  |   |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><b>1</b> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |  |  |  |   |  |   |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>A.G. Rao</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D35792</b>   |  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>JANUARY 26, 1996</b>  |  |   |  |   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Dr. Swaroop G. Rao MD Suite 504-50 West Edmonston Drive, Rockville, Md. 20852</b>   |  |  |  |  |  |  |  |   |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>JAN 29 1996</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Jan Davidson-Randall</b>   |  |  |  |   |  |   |  |   |  |  |  |

01037 71

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 048111

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

James Edward Price

2. Date of Death

Month Jan. Day 26 Year 1996

3. Time of Death

5:34am

4a. Facility Name (If not institution, give street and number)

The Memorial Hospital at Easton

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

Funeral  
Director

5. Social Security Number

216-38-7623

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

54 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Oct. 30, 1941

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Caroline

10c. City, Town or Location

Ridgely

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

23634 Henry Road- G, P.O. Box 121

10f. Zip Code

21660

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10th

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Manufacturing, Batteries

16b. Kind of Business/Industry

Johnson Control

17. Father's Name (First, Middle, Last)

Walter Price

18. Mother's Name (First, Middle, Maiden Surname)

Helen Pinkett

19a. Informant's Name/Relationship (Type, Print)

Gertrude W. Price

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

23634 Henry Road, P.O. Box 121, Ridgely, Md. 21660

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cokers Cemetery

Date

2/3/96

20c. Location - City or Town, State

Greensboro, Md.

21. Signature of Funeral Service Licensee

*John H. Prince*

22. Name and Address of Facility

Bennie Smith Funeral Home

P.O. Box 1687, Easton, Maryland 21601

23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

*Idiopathic Dilated Cardiomyopathy*  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

*years*

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?  
☐ Yes ☒ No

Hospital:

☐ Inpatient

☒ ER/Outpatient

☐ DOA

Other:

☐ Nursing Home

☐ Residence

☐ Other (Specify)

27. Manner of Death

☒ Natural

☐ Accident

☐ Suicide

☐ Homicide

☐ Pending investigation

☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Thomas W. Fauntleroy*

29c. License number

D15315

29d. Date signed (Month, Day, Year)

1/26/96

30. Name and address of person who completed causa of death (Item 23e) (Type, Print)

Thomas W. Fauntleroy, M.D., 403 Marvel Court, Easton, Md. 21601

31. Date filed (Month, Day, Year)

FEB 07 1996

32. Registrar's Signature

*John A. Anderson*

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR   |  |   |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 96 04812  |  |                                   |  |
|--|--|---|--|--|--|--|--|---|--|-----------------------------------|--|
| 1. DECEASED'S NAME (First, Middle, Last)   |  |   |  | 2. DATE OF DEATH   |  |  |  | 3. TIME OF DEATH  |  |                                   |  |
| Allmond Lloyd Perry  |  |   |  | February 11, 1996  |  |  |  | 6:05 A.M.   |  |                                   |  |
| 4. SOCIAL SECURITY NUMBER  |  | 5. SEX  |  | 6. AGE (In yrs. last birthday)   |  | 7. DATE OF BIRTH                               |  | 8. BIRTHPLACE (State or Foreign Country)                                    |  |                                   |  |
| 231-22-1600  |  | 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                              |  | 67 YRS.  |  | May 27, 1928                                   |  | Washington, D.C.  |  |                                   |  |
| 9a. FACILITY NAME (If not institution, give street and number)   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH  |  |  |  | 9c. COUNTY OF DEATH   |  |                                   |  |
| Residence: 524 Franklin Street   |  |   |  | Perryville   |  |  |  | Cecil   |  |                                   |  |
| 10a. STATE   |  |   |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION                    |  | 10d. INSIDE CITY LIMITS?  |  |                                   |  |
| Maryland   |  |   |  | Cecil  |  | Perryville                                     |  | 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO     |  |                                   |  |
| 10e. STREET AND NUMBER   |  |   |  | 10f. ZIP CODE  |  | 10g. CITIZEN OF WHAT COUNTRY?                  |  |   |  |                                   |  |
| 524 Franklin Street  |  |   |  | 21903  |  | U.S.A.   |  |   |  |                                   |  |
| 11. MARITAL STATUS   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN?   |  | 14. RACE — American Indian, Black, White, etc. |  |   |  |                                   |  |
| 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  | Specify: White                                 |  |   |  |                                   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)  |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)   |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |                                   |  |
| Elementary/Secondary (0-12) Twelve Years   |  |   |  | College (1-4 or 5+) -----  |  |  |  | Cecil County Court House Elkton, Maryland                                   |  |                                   |  |
| 17. FATHER'S NAME (First, Middle, Last)  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)  |  |  |  |   |  |                                   |  |
| Charles Irving Perry   |  |   |  | Minnie Florence Green  |  |  |  |   |  |                                   |  |
| 19a. INFORMANT'S NAME (Type/Print)   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)  |  |  |  |   |  |                                   |  |
| Naomi P. Perry   |  |   |  | 524 Franklin Street, Perryville, Maryland 21903  |  |  |  |   |  |                                   |  |
| 20a. METHOD OF DISPOSITION   |  |   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)  |  |  |  | 20c. LOCATION — City or Town, State   |  |                                   |  |
| 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |   |  | Harmony Chapel Cemetery 2/13/96  |  |  |  | Liberty Grove, Maryland   |  |                                   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  |  |   |  | 22. NAME AND ADDRESS OF FACILITY   |  |  |  |   |  |                                   |  |
| Thomson M. Patterson, Sr.  |  |   |  | Lee A. Patterson & Son Funeral Home Perryville, Maryland 21903   |  |  |  |   |  |                                   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |  |  |  |  | Approximate Interval Between Onset and Death                                |  |                                   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  |   |  |  |  |  |  |   |  |                                   |  |
| a. Arrhythmia  |  |   |  |  |  |  |  |   |  |                                   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |  |  |  |  |   |  |                                   |  |
| b. Severe Chronic Renal Failure  |  |   |  |  |  |  |  | One year  |  |                                   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |  |  |  |  |   |  |                                   |  |
| c. Hypertension  |  |   |  |  |  |  |  | unknown   |  |                                   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |  |  |  |  |   |  |                                   |  |
| d. Tobacco abuse   |  |   |  |  |  |  |  |   |  |                                   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  |  |  |   |  |                                   |  |
| 24a. WAS AN AUTOPSY PERFORMED?   |  |   |  |  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |  |                                   |  |
| 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |   |  |  |  |  |  | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |                                   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |   |  |  |  |  |  |   |  |                                   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?   |  |   |  | 26. PLACE OF DEATH (Check only one)  |  |  |  |   |  |                                   |  |
| 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |   |  | HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |   |  |                                   |  |
| 27. MANNER OF DEATH  |  |   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY                            |  | 28c. INJURY AT WORK?  |  | 28d. DESCRIBE HOW INJURY OCCURRED |  |
| 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |  |   |  |  |  | M  |  | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |                                   |  |
| 29a. CERTIFIER (Check only one)  |  |   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER  |  | 29c. LICENSE NUMBER                            |  | 29d. DATE SIGNED (Month, Day, Year)   |  |                                   |  |
| 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  | Leila Kirdani-Ryan MD  |  | D446467  |  | Feb 12, 1996  |  |                                   |  |
| 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |  |  |  |  |   |  |                                   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  |  |   |  | 31. DATE FILED (Month, Day, Year)  |  | 32. REGISTRAR'S SIGNATURE                      |  |   |  |                                   |  |
| Leila Kirdani-Ryan MD, 101 Colonial Way, Suite A, Rising Sun MD  |  |   |  | FEB 13 1996  |  | Julia Davidson-Randall                         |  |   |  |                                   |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04813

|  |   |  |   |  |  |  |   |  |
|--|---|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>MICHAEL DEAN PIRNER</b>  |  |   |  | 2. Date of Death<br>Month <b>FEB.</b> Day <b>08</b> , Year <b>1996</b>   |  | 3. Time of Death<br><b>2:25 AM</b>                                      |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>162 SMALLWOOD VILLAGE CIRCLE</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>WALDORF</b>   |  | 4c. County of Death<br><b>CHARLES</b>                                   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>219-11-2675</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>25</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>APRIL 17, 1970</b>            |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>   |  | 10e. State<br><b>MARYLAND</b>   |  | 10b. County<br><b>CHARLES</b>  |  | 10c. City, Town or Location<br><b>WALDORF</b>                           |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>P.O. BOX 1320</b>  |  | 10f. Zip Code<br><b>20604</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                          |  |
|  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b> |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>SHIFT MANAGER</b>                 |  | 16b. Kind of Business/Industry<br><b>RESTUARANT</b>  |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>LEONARD J. PIRNER</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ANN S. RAWLINGS</b>  |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>ANN S. PIRNER</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P.O. BOX 1320 WALDORF, MARYLAND 20604</b>  |  |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>TRINITY MEMORIAL GARDENS</b>   |  | 20c. Date<br><b>2/13/96</b>  |  | 20d. Location - City or Town, State<br><b>WALDORF, MARYLAND</b>         |  |
|  | 21. Signature of Funeral Service Licensee<br><br><b>BENJAMIN M. MATTHEWS M-00658</b>  |  | 22. Name and Address of Facility<br><b>THE HUNTT FUNERAL HOME, INC.<br/>P.O. BOX 156 WALDORF, MARYLAND 20604</b>                                  |  |  |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>GUNSHOT WOUND OF HEAD</b><br>Due to (or as a consequence of):<br><br>b. _____ Due to (or as a consequence of):<br><br>c. _____ Due to (or as a consequence of):<br><br>d. _____<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |  |   |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |   |  |  |  |   |  |
|  | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |  |  |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |   |  |  |  |   |  |
| Physician<br>/Medical<br>Examiner  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  |   |  |
|  | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |  |  |  |   |  |
|  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>RESTUARANT</b>   |  |   |  |  |  |   |  |
|  | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  |   |  |  |  |   |  |
| To Be Completed by Physician/Medical Examiner  | 28a. Date of Injury (Month, Day Year)<br><b>2/7/96</b>  |  | 28b. Time of Injury<br><b>1100 P M</b>  |  | 28c. Injury at Work?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 28d. Describe how injury occurred<br><b>SUBJECT SHOT</b>                |  |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>RESTAURANT</b>   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>162 SMALLWOOD VILLAGE CENTER WALDORF, MD</b>                   |  |  |  |   |  |
|  | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |  |  |   |  |
|  | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>O.C.M.E</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>FEBRUARY 8, 1996</b>   |  |   |  |
| State<br>Registrar   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>MARIO F. GOVE JR MD 111 Penn Street, Baltimore, Maryland 21201</b>   |  |   |  |  |  |   |  |
|  | 31. Date filed (Month, Day, Year)<br><b>FEB 13 1996</b>   |  | 32. Registrar's Signature<br>                                  |  |  |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





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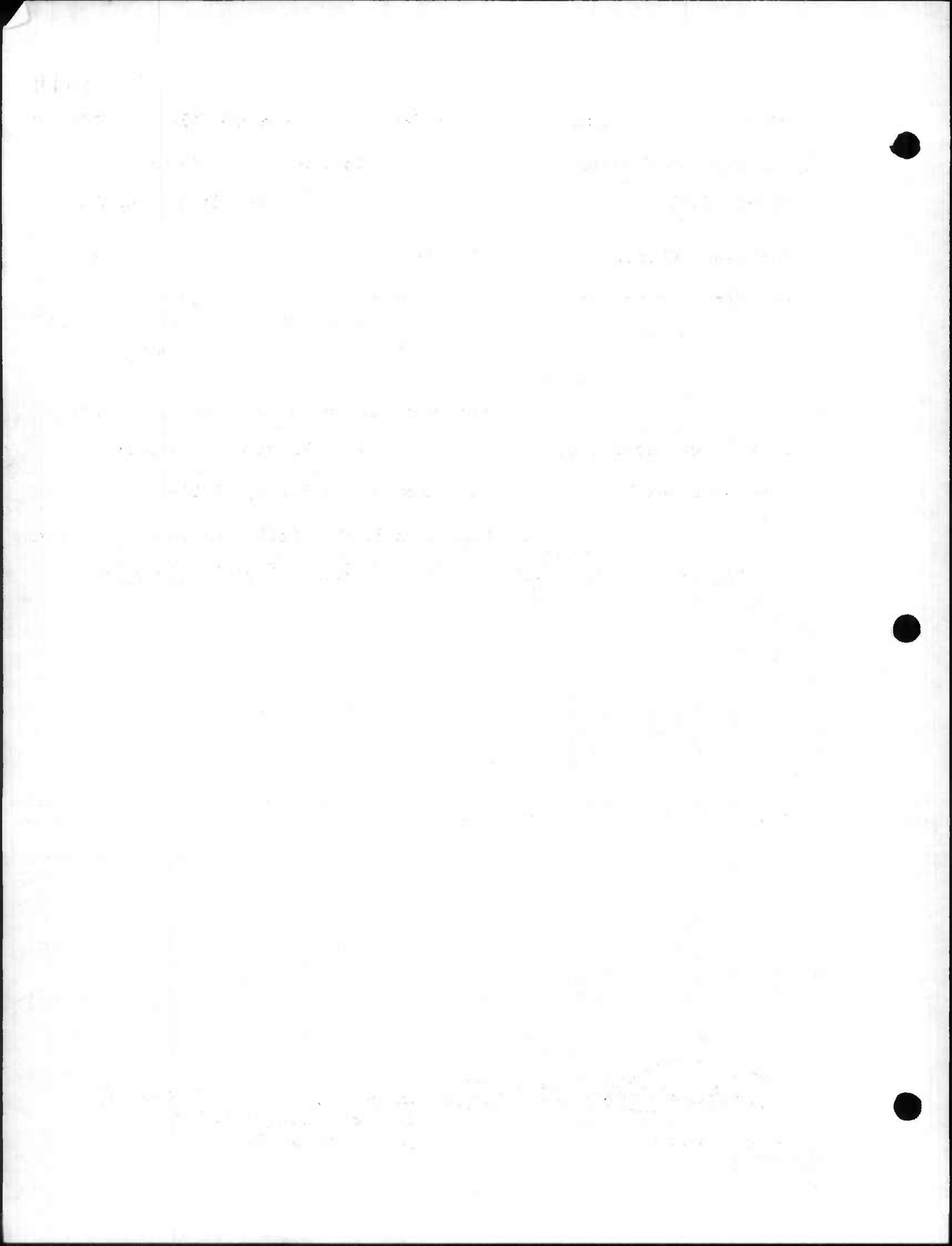
State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04814

|  |   |  |   |  |  |  |  |  |
|--|---|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner                | 1. Decedent's Name (First, Middle, Last)<br>Diane Louise Pawulak  |  |   |  | 2. Date of Death<br>February 7, 1996   |  | 3. Time of Death<br>11:20 PM                                     |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Physicians Memorial Hospital  |  |   |  | 4b. City, Town, or Location of Death<br>La Plata   |  | 4c. County of Death<br>Charles                                   |  |
| Funeral<br>Director                              | 5. Social Security Number<br>115-40-9041  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>48 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>July 5, 1947              |  |
|  | 9. Birthplace (State or Foreign Country)<br>New York  |  | 10a. State<br>Maryland  |  | 10b. County<br>Charles   |  | 10c. City, Town or Location<br>La Plata                          |  |
| To Be Completed by<br>Funeral Director           | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br>603 Wicomico Street   |  | 10f. Zip Code<br>20646   |  | 10g. Citizen of What Country?<br>U.S.A.                          |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |
| To Be Completed by<br>Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>2   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Antique Store Operator   |  | 16b. Kind of Business/Industry<br>Antiques-Retail  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>John Forest Jones, Sr.   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Anna Margaret Dick Jones   |  | 19a. Informant's Name/Relationship (Type, Print)<br>John D. Pawulak  |  |  |  |
| To Be Completed by<br>Physician/Medical Examiner | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>P.O. Box 203 La Plata, MD 20646  |  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Arlington Natl. Cem. 2/15  |  | 20c. Location - City or Town, State<br>Arlington, Virginia       |  |
|  | 21. Signature of Funeral Service Licensee<br>M00817<br>Highton C. Scholte   |  | 22. Name and Address of Facility<br>Arehart-Echols Funeral Home, Inc.<br>P.O. Box 567 La Plata, MD 20646  |  |  |  |  |  |
| To Be Completed by<br>Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Sepsis<br>Due to (or as a consequence of):<br>b. Neutropenia<br>Due to (or as a consequence of):<br>c. Intestinal obstruction<br>Due to (or as a consequence of):<br>d. Ovarian cancer with metastases |  |   |  |  |  |  |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |   |  |  |  |  |  |
| To Be Completed by<br>Physician/Medical Examiner | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |  |  |  |  |
|  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |  |  |  |  |  |
| To Be Completed by<br>Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |  |  |  |  |
|  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |   |  |  |  |  |  |
| To Be Completed by<br>Physician/Medical Examiner | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  |   |  |  |  |  |  |
|  | 28a. Date of Injury (Month, Day Year)<br>28b. Time of Injury<br>28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>28d. Describe how injury occurred<br>28e. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |  |  |  |
| To Be Completed by<br>Physician/Medical Examiner | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |  |  |  |  |
|  | 29b. Signature and title of certifier<br>Paul Pritchett, M.D.<br>29c. License number<br>D-08370<br>29d. Date signed (Month, Day, Year)<br>2/8/96  |  |   |  |  |  |  |  |
| To Be Completed by<br>Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Paul Pritchett, M.D.<br>118 LaGrange Avenue, PO Box 1317<br>La Plata, Maryland 20646  |  |   |  |  |  |  |  |
|  | 31. Date filed (Month, Day, Year)<br>FEB 09 1996<br>32. Registrar's Signature<br>Julia Shuler Randall   |  |   |  |  |  |  |  |



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR   |  |   |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 96 04815  |  |   |  |  |  |
|---|--|---|--|--|--|--|--|---|--|---|--|--|--|
| CERTIFICATE OF DEATH  |  |   |  | REG. NO.   |  |  |  |   |  |   |  |  |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>RONALD ALBERT PRESTELE</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH <b>FEBRUARY</b> DAY <b>7</b> , YEAR <b>1996</b>  |  |  |  | 3. TIME OF DEATH<br><b>1:55 A M</b>   |  |   |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>578-48-0357</b>   |  | 5. SEX<br><b>XX M</b> 2 <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>60</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>     |  | IF UNDER 24 HRS.<br>HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>JAN. 7, 1936</b> |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>WASHINGTON DC</b> |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>802 AVEDON COURT</b>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>WALDORF</b>  |  |  |  | 9c. COUNTY OF DEATH<br><b>CHARLES</b>   |  |   |  |  |  |
| RESIDENCE OF DECEDENT   |  |   |  |  |  |  |  |   |  |   |  |  |  |
| 10a. STATE<br><b>MARYLAND</b>   |  | 10b. COUNTY<br><b>CHARLES</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>WALDORF</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |   |  |  |  |
| 10e. STREET AND NUMBER<br><b>802 AVEDON COURT</b>   |  |   |  | 10f. ZIP CODE<br><b>20602</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>UNITED STATES</b>   |  |   |  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>KOREAN &amp; VIETNAM</b> |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>  |  |   |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>  |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>LOCKSMITH</b>  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>SECURITY</b>   |  |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>ALBERT E. PRESTELE</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>MARY NASH</b>  |  |  |  |   |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>GERTRUD MARGARET PRESTELE</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>802 AVEDON COURT, WALDORF, MARYLAND 20602</b>  |  |  |  |   |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place)<br><b>MD VETERANS CEMETERY FEB. 12, 1996 CHELTENHAM, MD</b>   |  |  |  | 20c. LOCATION — City or Town, State   |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>MARK G. BROHAWN</b>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>THE HUNTT FUNERAL HOME, INC.<br/>P.O. BOX 156, WALDORF, MARYLAND 20604</b>  |  |  |  |   |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Squamous cell cancer of Right Lung, Stage III A</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b.<br>c.<br>d.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>DUE TO (OR AS A CONSEQUENCE OF): |  |   |  | Approximate Interval Between Onset and Death<br><b>5 mos.</b>  |  |  |  |   |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |   |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE NOW INJURY OCCURRED   |  |   |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |   |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Kai-Yu Yeung, MD</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D14730</b>  |  |   |  |  |  |
| 29d. DATE SIGNED (Month, Day, Year)<br><b>2/7/96</b>  |  |   |  |  |  |  |  |   |  |   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Kai-Yu Yeung, MD 8826 Woodward Road #201 Clinton, MD 20735</b>  |  |   |  |  |  |  |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 09 1996</b>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><b>Jahia Davidson Randall</b>   |  |  |  |   |  |   |  |  |  |

3184

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04816

|  |  |  |  |   |  |  |  |   |  |   |  |
|--|--|--|--|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>T H O M A S P A R R A N</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>FEBRUARY</b> DAY <b>7</b> YEAR <b>1996</b>   |  | 3. TIME OF DEATH<br><b>1:54 P M</b>  |  |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>577-14-7039</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>91</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Feb. 28, 1904</b>                      |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>SOUTHERN MARYLAND HOSPITAL</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>CLINTON</b>   |  |  |  | 9c. COUNTY OF DEATH<br><b>PRINCE GEORGES</b>  |  |   |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Prince George's</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Riverdale</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO       |  |   |  |
| 10e. STREET AND NUMBER<br><b>5603 Carters Lane</b>   |  |  |  | 10f. ZIP CODE<br><b>20737</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                      |  |   |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>          |  |   |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>3</b><br>College (1-4 or 5+) <b>College</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Laborer</b>  |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Construction</b>                            |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Jacob Parran</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Jennie Kelson</b>   |  |  |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Hazel V. Thomas</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5603 Carters Lane Riverdale, MD 20737</b>   |  |  |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Church of God Cemetery 2/10/96</b>   |  | 20c. LOCATION — City or Town, State<br><b>Lothian, MD</b>   |  |  |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Spencer S. Sewell</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Sewell Funeral Home<br/>1451 Dares Beach Rd. Prince Frederick, MD</b>  |  |  |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Diabetic ketoacidosis</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>SEPSIS - HYPOTENSION</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <b>resp-arrest</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |  |  | Approximate Interval Between Onset and Death<br><b>18hrs.</b>   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Renal failure</b>   |  |  |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |  |   |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>SMS</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D46478</b>  |  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>2-8-96</b>  |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Suresh A. Patel, M.D. 7501 Surratts Rd. #302, Clinton, MD 20735</b>  |  |  |  |   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB - 9 1996</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |  |  |  |   |  |   |  |

10/1/64

Dear Mr. [illegible]

I am writing to you regarding the [illegible]

which you have been [illegible]

and the [illegible]

which you have been [illegible]

and the [illegible]

and the [illegible]

and the [illegible]

and the [illegible]

and the [illegible]

and the [illegible]

and the [illegible]

and the [illegible]

and the [illegible]

and the [illegible]

and the [illegible]

and the [illegible]

and the [illegible]

and the [illegible]

and the [illegible]

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the funeral-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 048117

|  |  |  |  |   |  |  |   |   |   |  |
|--|--|--|--|---|--|--|---|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>IRVING MILTON PARKER SR.</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>01</b> DAY <b>30</b> YEAR <b>96</b>  |  | 3. TIME OF DEATH<br><b>1330 M</b>  |   |   |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216-18-2188</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>72</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>08-07-23</b>                           |   | 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>                                     |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>31339 OLD OCEAN CITY ROAD</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>SALISBURY</b>   |  |  | 9c. COUNTY OF DEATH<br><b>WICOMICO</b>  |   |   |  |
| 10a. STATE<br><b>Pennsylvania</b>  |  |  |  | 10b. COUNTY<br><b>Philadelphia</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Philadelphia</b>                               |   | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |   |  |
| 10e. STREET AND NUMBER<br><b>1808 E. Letterly</b>  |  |  |  | 10f. ZIP CODE<br><b>19125</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                      |   |   |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WW II</b>   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>       |   |   |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b><br>College (1-4 or 5+) <b>0</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Machine Operator</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Soda Bottling Co.</b>  |  |  |   |   |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Harley Parker</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Bertha Insley</b>   |  |  |   |   |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Faye E. Banks</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>30819 Johnson Rd., Salisbury, MD 21801</b>  |  |  |   |   |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Parsons Cemetery</b>   |  | OATE<br><b>2/3</b>  |  | 20c. LOCATION — City or Town, State<br><b>Salisbury, MD</b>                      |   |   |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Holloway Funeral Home<br/>501 Snow Hill Rd., Salisbury, MD 21801</b>   |  |  |   |   |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br><br>d. |  |  |  |   |  |  | Approximate interval Between Onset and Death  |   |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>POST CORONARY BYPASS, PERIPHERAL VASCULAR OCCLUSIVE DISEASE, ALZHEIMERS DISEASE</b>   |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |   |   |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |   | 28d. DESCRIBE HOW INJURY OCCURRED   |   |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>John G. Bulkeley, M.D., D.M.E.</b>   |  |   |  | 29c. LICENSE NUMBER<br><b>D03599</b>   |   | 29d. DATE SIGNED (Month, Day, Year)<br><b>01-31-96</b>  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>JOHN T. BULKELEY, M.D., 108 PINE BLUFF ROAD, SALISBURY, MD 21801</b>   |  |  |  |   |  |  |   |   |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 01 1996</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>  |  |  |   |   |   |  |

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR   |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 96 04818  |  |
|---|--|--|--|---|--|---|--|---|--|
| CERTIFICATE OF DEATH  |  |  |  | REG. NO.  |  |   |  |   |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>NORMAN G. PAULHUS</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>JAN</b> DAY <b>31</b> YEAR <b>96</b>   |  | 3. TIME OF DEATH<br><b>1:30 A M</b>   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>291-12-4128</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br><b>82</b> YRS. | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>  | IF UNDER 24 HRS.<br>HOURS <b></b> MIN. <b></b> | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>MAY 28, 1913</b>                                   |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>CONNECTICUT</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>BROOKE GROVE NURSING HOME</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>OLNEY</b>   |  | 9c. COUNTY OF DEATH<br><b>MONTGOMERY</b>  |  |   |  |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |   |  |   |  |
| 10a. STATE<br><b>MARYLAND</b>   |  | 10b. COUNTY<br><b>MONTGOMERY</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>DERWOOD</b>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |   |  |
| 10e. STREET AND NUMBER<br><b>18816 MUNCASTER ROAD</b>   |  |  |  | 10f. ZIP CODE<br><b>20855</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>UNITED STATES</b>   |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WW II</b>  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                         |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>7</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>ECONOMIST</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>U. S. GOVERNMENT</b>   |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>JOSEPH F. PAULHUS</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>MARIE LAVESQUE</b>  |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>KATHRYN F. PAULHUS WIFE</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>18816 MUNCASTER ROAD, DERWOOD, MARYLAND 20855</b>   |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>GATE OF HEAVEN</b>   |  | DATE<br><b>2/3/96</b>   |  | 20c. LOCATION — City or Town, State<br><b>SILVER SPRING, MD.</b>                                |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Muriel H. Barber</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>MURIEL H. BARBER FUNERAL HOME 20882 P O BOX 5038 LAYTONSVILLE, MARYLAND</b>  |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ASPIRATION PNEUMONIA</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Approximate Interval Between Onset and Death<br><b>24 HOURS</b> |  |  |  |   |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>ADVANCED ALZHEIMER'S DEMENTIA</b>  |  |  |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  |   |  |   |  |   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  |   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  | 28d. DESCRIBE NOW INJURY OCCURRED   |  |
|   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Joseph M.D.</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D33700</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>1-31-96</b>   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>TED E. HOWE 18100 SCADY SCHOOL RD. SAURY SPRING, MD</b>   |  |  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 16 1996</b>   |  | 32. REGISTRAR'S SIGNATURE<br><b>John Anderson</b>  |  |   |  |   |  |   |  |

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR  |  |   |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 96 048119   |  |   |  |   |  |
|---|--|---|--|---|--|--|--|---|--|---|--|---|--|
| CERTIFICATE OF DEATH  |  |   |  | REG. NO.  |  |  |  |   |  |   |  |   |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Arah Elfreda PUTNAM   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>February 4, 1996  |  |  |  | 3. TIME OF DEATH<br>4:00 P M  |  |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br>234-38-8862  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>70 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>Mar. 31, 1925   |  | 8. BIRTHPLACE (State or Foreign Country)<br>West Virginia |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Garrett County Memorial Hospital  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Oakland  |  |  |  | 9c. COUNTY OF DEATH<br>Garrett  |  |   |  |   |  |
| RESIDENCE OF DECEDENT   |  |   |  |   |  |  |  |   |  |   |  |   |  |
| 10a. STATE<br>MD  |  | 10b. COUNTY<br>Garrett  |  | 10c. CITY, TOWN OR LOCATION<br>Mt. Lake Park  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO       |  |   |  |   |  |
| 10e. STREET AND NUMBER<br>607 N St., Apt. 25  |  |   |  | 10f. ZIP CODE<br>21550  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  |   |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White  |  |   |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5 +)   |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Manager  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Laundramat  |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Eddie Shaw   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Blanche Friend   |  |  |  |   |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Martha Martin   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>508 Oak St., Mt. Lake Park, MD 21550   |  |  |  |   |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Garrett Co. Mem. Gardens 2/7   |  | DATE<br>2/7   |  | 20c. LOCATION — City or Town, State<br>Oakland, Maryland                             |  |   |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Brody, A. Sherrill   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>Stewart Funeral Home<br>32 S. Second St., Oakland, MD 21550   |  |  |  |   |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive Heart Failure<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. Acute Myocardial Infarction<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. Coronary Artery Disease<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |   |  |   |  |  |  | Approximate interval Between Onset and Death<br>Hours<br>Hours<br>Years                                   |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |   |  |   |  |  |  |   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |   |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |  |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Dr. Keith Merritt, 311 N Fourth St., Oakland, MD 21550   |  |   |  |   |  | 29c. LICENSE NUMBER<br>D47309  |  | 29d. DATE SIGNED (Month, Day, Year)<br>2/5/96   |  |   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Dr. Keith Merritt, 311 N Fourth St., Oakland, MD 21550   |  |   |  |   |  |  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>FEB - 6 1996   |  |   |  | 32. REGISTRAR'S SIGNATURE<br>John Anderson-Randall  |  |  |  |   |  |   |  |   |  |



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR  |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 96 04820   |  |
|--|--|--|--|---|--|---|--|--|--|
| CERTIFICATE OF DEATH   |  |  |  | REG. NO.  |  |   |  |  |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>EVERETT L. RUSH</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>FEBRUARY</b> DAY <b>11</b> YEAR <b>1996</b>  |  |   |  | 3. TIME OF DEATH<br><b>4:08 P.M.</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>299-03-0554</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br><b>82</b> YRS. | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>  |  | IF UNDER 24 HRS.<br>HOURS <b></b> MIN. <b></b>  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>JUNE 4, 1913</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>OHIO</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>HOLY CROSS HOSPITAL</b>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>SILVER SPRING</b>  |  |
| 9c. COUNTY OF DEATH<br><b>MONTGOMERY</b>   |  |  |  | 10a. STATE<br><b>MARYLAND</b>   |  |   |  | 10b. COUNTY<br><b>MONTGOMERY</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>LAYTONSVILLE</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  |  |  |
| 10e. STREET AND NUMBER<br><b>28804 GREENBERRY DRIVE</b>  |  |  |  | 10f. ZIP CODE<br><b>20882</b>   |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>UNITED STATES</b>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WWII</b>  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>                  |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>0</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>CARPENTER</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>CONSTRUCTION</b>   |  |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>DENNIS RUSH</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>WILHELMINA ASHCOFF</b>  |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>LEAH C. PRESSEL, DAUGHTER</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>28804 GREENBERRY DRIVE, LAYTONSVILLE, MD. 20882</b>   |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>MD. NATIONAL MEMORIAL PARK 2/15</b>  |  | 20c. LOCATION — City or Town, State<br><b>LAUREL, MARYLAND</b>  |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>MURIEL H. BARBER FUNERAL HOME 20882<br/>P.O. BOX 5038 LAYTONSVILLE, MARYLAND</b>  |  |   |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>PULMONARY EMBOLUS</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { <b>DVT</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>GLIOBLASTOMA GRADE IV</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Approximate Interval Between Onset and Death<br><b>1 HOUR</b><br><b>4-5 DAYS</b><br><b>2 MONTHS</b> |  |  |  |   |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>ASTHMA COPD.</b>  |  |  |  |   |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |   |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>  |  |  |  |   |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>NA</b>  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28i. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>  |  |   |  | 29c. LICENSE NUMBER<br><b>D 43243</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>FEB 11 1996</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>JOHN CASEY MD</b>  |  |  |  | 31. DATE FILED (Month, Day, Year)<br><b>FEB 21 1996</b>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br>  |  |



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1 - FOR STATE REGISTRAR   |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 96 04821  |  |                                    |  |
|---|--|--|--|---|--|---|--|---|--|------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)  |  |  |  | 2. DATE OF DEATH  |  |   |  | 3. TIME OF DEATH  |  |                                    |  |
| ALTA MARIE RICE   |  |  |  | FEBRUARY 6, 1996  |  |   |  | 7:00P <sup>M</sup>  |  |                                    |  |
| 4. SOCIAL SECURITY NUMBER   |  | 5. SEX   |  | 6. AGE (In yrs. last birthday)  |  | 7. DATE OF BIRTH  |  | 8. BIRTHPLACE (State or Foreign Country)  |  | 9. COUNTY OF DEATH                 |  |
| 216-09-4815   |  | 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 84 YRS.   |  | Dec. 11, 1911   |  | Maryland  |  | Washington                         |  |
| 9a. FACILITY NAME (If not institution, give street and number)  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH   |  |   |  | 9c. COUNTY OF DEATH   |  |                                    |  |
| Ravenwood Lutheran Village  |  |  |  | Hagerstown  |  |   |  | Washington  |  |                                    |  |
| RESIDENCE OF DECEDENT   |  |  |  | 10c. CITY, TOWN OR LOCATION   |  |   |  | 10d. INSIDE CITY LIMITS?  |  |                                    |  |
| 10a. STATE  |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION   |  | 10d. INSIDE CITY LIMITS?  |  | 10e. STREET AND NUMBER  |  | 10f. ZIP CODE                      |  |
| Maryland  |  | Washington   |  | Highfield   |  | 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                       |  | 25438 Warren Avenue   |  | 21719                              |  |
| 11. MARITAL STATUS  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN?  |  | 14. RACE — American Indian, Black, White, etc.  |  | 15. DECEDENT'S EDUCATION  |  | 16. DECEDENT'S USUAL OCCUPATION    |  |
| 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married   |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | Specify: White  |  | Elementary/Secondary (0-12)   |  | Homemaker                          |  |
| 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | IF YES, GIVE WAR OR DATES  |  | If yes, specify Cuban, Mexican, Puerto Rican, etc.)   |  | Specify:  |  | College (1-4 or 5+)   |  | Home                               |  |
| 17. FATHER'S NAME (First, Middle, Last)   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)  |  | 19a. INFORMANT'S NAME (Type/Print)  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |  | 20a. METHOD OF DISPOSITION  |  | 20b. PLACE AND DATE OF DISPOSITION |  |
| Lawson Poole  |  | Anna Ott   |  | Richard K. Rice   |  | P.O. Box 356 Smithsburg, Md. 21783  |  | 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State |  | Bethel Cemetery 2/10/96            |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE   |  | 22. NAME AND ADDRESS OF FACILITY   |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. |  | 24a. WAS AN AUTOPSY PERFORMED?  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?   |  |                                    |  |
|   |  | Davis Funeral Home<br>12525 Bradbury Ave.<br>Smithsburg, MD 21783  |  | IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Respiratory  |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                       |  | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |                                    |  |
|   |  |  |  | b. Sepsis   |  |   |  |   |  |                                    |  |
|   |  |  |  | c. Due to (OR AS A CONSEQUENCE OF):   |  |   |  |   |  |                                    |  |
|   |  |  |  | d. Due to (OR AS A CONSEQUENCE OF):   |  |   |  |   |  |                                    |  |
|   |  |  |  | PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  |                                    |  |
|   |  |  |  | Chronic Brain Syndrome with Dementia  |  |   |  |   |  |                                    |  |
|   |  |  |  | Parkinsons Disease  |  |   |  |   |  |                                    |  |
|   |  |  |  | Psychotic Disorder, NOS   |  |   |  |   |  |                                    |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?  |  | 26. PLACE OF DEATH (Check only one)  |  | 27. MANNER OF DEATH   |  | 28a. DATE OF INJURY   |  | 28b. TIME OF INJURY   |  |                                    |  |
| 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA                       |  | 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation  |  | (Month, Day, Year)  |  | M   |  |                                    |  |
|   |  | 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  | 2 <input type="checkbox"/> Accident   |  | 28c. INJURY AT WORK?  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |                                    |  |
|   |  |  |  | 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined   |  | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                  |  |   |  |                                    |  |
|   |  |  |  | 4 <input type="checkbox"/> Homicide   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)        |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |                                    |  |
| 29a. CERTIFIER (Check only one)   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER  |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)   |  |   |  |                                    |  |
| 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                      |  |  |  | D07857  |  | 2/8/96  |  |   |  |                                    |  |
| 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |   |  |                                    |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)   |  | 31. DATE FILED (Month, Day, Year)  |  | 32. REGISTRAR'S SIGNATURE   |  |   |  |   |  |                                    |  |
| Dr. Moody 1190 Mt. Aetna Rd Hagerstown, MD 21740  |  | FEB 9 1996   |  |   |  |   |  |   |  |                                    |  |

1897



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR   |  |  |                                | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE                                   |  |  |  | 96 04822   |  |  |  |
|---|--|--|--------------------------------|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)  |  |  |                                | 2. DATE OF DEATH  |  |  |  | 3. TIME OF DEATH   |  |  |  |
| Alice Elaine Rudolph  |  |  |                                | February 1 1996   |  |  |  | 2303 P   |  |  |  |
| 4. SOCIAL SECURITY NUMBER   |  | 5. SEX   | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR   |  | IF UNDER 24 HRS.                               |  | 7. DATE OF BIRTH   |  | 8. BIRTHPLACE (State or Foreign Country)                     |  |
| 213 46 2764   |  | 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   | 79 YRS.                        | MONTHS DAYS   |  | HOURS MIN.                                     |  | 5/5/16   |  | Maryland   |  |
| 9a. FACILITY NAME (If not institution, give street and number)  |  |  |                                | 9b. CITY, TOWN OR LOCATION OF DEATH   |  |  |  | 9c. COUNTY OF DEATH  |  |  |  |
| Washington County Hospital  |  |  |                                | Hagerstown  |  |  |  | Washington   |  |  |  |
| RESIDENCE OF DECEDENT   |  |  |                                | 10c. CITY, TOWN OR LOCATION   |  |  |  | 10d. INSIDE CITY LIMITS?   |  |  |  |
| 10a. STATE  |  | 10b. COUNTY  |                                | Hagerstown  |  |  |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO      |  |  |  |
| Maryland  |  | Washington   |                                |   |  |  |  |  |  |  |  |
| 10e. STREET AND NUMBER  |  |  |                                | 10f. ZIP CODE   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?  |  |  |  |
| 10701 Lincoln Ave.  |  |  |                                | 21740   |  |  |  | USA  |  |  |  |
| 11. MARITAL STATUS  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?  |                                | 13. WAS DECEDENT OF HISPANIC ORIGIN?  |  | 14. RACE — American Indian, Black, White, etc. |  |  |  |  |  |
| 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married   |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |                                | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                       |  | Specify: White                                 |  |  |  |  |  |
| 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | IF YES, GIVE WAR OR DATES  |                                | Specify:  |  |  |  |  |  |  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)                     |                                | 18b. KIND OF BUSINESS/INDUSTRY  |  |  |  |  |  |  |  |
| Elementary/Secondary (0-12)   |  | College (1-4 or 5 +)   |                                | sales representative  |  | Singer Sewing Mach. Co.                        |  |  |  |  |  |
| 12  |  |  |                                |   |  |  |  |  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)   |  |  |                                | 18. MOTHER'S NAME (First, Middle, Maiden Surname)   |  |  |  |  |  |  |  |
| John Austin Habercam  |  |  |                                | Harriett Spicer   |  |  |  |  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)  |  |  |                                | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |  |  |  |  |  |  |  |
| James F. Rudolph  |  |  |                                | 17630 Meadowood Dr. Hagerstown, Md. 21740   |  |  |  |  |  |  |  |
| 20a. METHOD OF DISPOSITION  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)  |                                | DATE  |  | 20c. LOCATION — City or Town, State            |  |  |  |  |  |
| 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State   |  | Green Lawn Mem. Park 2/5   |                                |   |  | Williamsport, Md.                              |  |  |  |  |  |
| 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |                                |   |  |  |  |  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE   |  |  |                                | 22. NAME AND ADDRESS OF FACILITY  |  |  |  |  |  |  |  |
| Gerald N. Minnich   |  |  |                                | Gerald N. Minnich 305 N. Potomac St. Hagerstown, Md.  |  |  |  |  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. |  |  |                                |   |  |  |  | Approximate Interval Between Onset and Death                                 |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →   |  |  |                                |   |  |  |  | 2 hrs  |  |  |  |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  |  |                                |   |  |  |  |  |  |  |  |
| a. DUE TO (OR AS A CONSEQUENCE OF):   |  |  |                                |   |  |  |  |  |  |  |  |
| b. DUE TO (OR AS A CONSEQUENCE OF):   |  |  |                                |   |  |  |  |  |  |  |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):   |  |  |                                |   |  |  |  |  |  |  |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):   |  |  |                                |   |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |                                |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?   |  |  |  |
|   |  |  |                                |   |  |  |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO      |  |  |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |                                |   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  |  |  |  |
|   |  |  |                                |   |  |  |  | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                 |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?  |  | 26. PLACE OF DEATH (Check only one)  |                                | 27. MANNER OF DEATH   |  | 28a. DATE OF INJURY                            |  | 28b. TIME OF INJURY  |  | 28c. INJURY AT WORK?   |  |
| 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA         |                                | 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation           |  | (Month, Day, Year)                             |  | M  |  | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
|   |  | OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                | 2 <input type="checkbox"/> Accident   |  |  |  |  |  |  |  |
|   |  |  |                                | 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined         |  |  |  |  |  |  |  |
|   |  |  |                                | 4 <input type="checkbox"/> Homicide   |  |  |  |  |  |  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |                                | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)        |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |  |  |  |
|   |  |  |                                |   |  |  |  |  |  |  |  |
| 29a. CERTIFIER (Check only one)   |  |  |                                | 29b. SIGNATURE AND TITLE OF CERTIFIER   |  |  |  | 29c. LICENSE NUMBER  |  | 29d. DATE SIGNED (Month, Day, Year)                          |  |
| 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                   |  |  |                                | [Signature]   |  | [Signature]                                    |  | [Signature]  |  | 2-2-96   |  |
| 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |                                |   |  |  |  |  |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)   |  |  |                                | 31. DATE FILED (Month, Day, Year)   |  |  |  | 32. REGISTRAR'S SIGNATURE  |  |  |  |
| E. J. Henderson 582 P.M. Hagerstown, Md 21740   |  |  |                                | FEB 5 1996  |  |  |  | [Signature]  |  |  |  |



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04823

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Blanche Lovetta Rice</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Feb 2 1996</b>   |  | 3. TIME OF DEATH<br><b>2:10 P.M.</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>213-74-1459</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>102</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>MARCH 6, 1893</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>MARYLAND</b>   |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>FAHRNEY -KEEDY MEMORIAL HOME</b>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BOONSBORO</b>   |  |
| 9c. COUNTY OF DEATH<br><b>WASHINGTON</b>  |  |  |  | 10a. STATE<br><b>MARYLAND</b>   |  |   |  |
| 10b. COUNTY<br><b>WASHINGTON</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>ROHRERSVILLE</b>   |  |   |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>4335 MAIN STREET</b>   |  |  |  | 10f. ZIP CODE<br><b>21779</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>                          |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6</b><br>College (1-4 or 5+) <b>6</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>HOMEMAKER</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>OWN HOME</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>SILAS THOMAS</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>SUSAN HAMMOND</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>RHODA RICE</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P.O. BOX 38, ROHRERSVILLE, MARYLAND 21779</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Mt. Zion Cemetery</b>  |  | 20c. DATE<br><b>2/6/96</b>  |  | 20d. LOCATION — City or Town, State<br><b>LOCUST GROVE, MARYLAND</b>                                |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Paul M. Dean</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>BAST FUNERAL HOME 7606 Old National Pike Boonsboro, Maryland 21713</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>SEPSIS</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>Urinary Tract Infection</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <b>Dehydration</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br><br>Approximate Interval Between Onset and Death<br><b>1 Day</b><br><b>2 Days</b><br><b>5 Days</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Cerebrovascular accident</b><br><b>Senile Dementia</b>   |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>[Signature]</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D44996</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>Feb 2, 1996</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>ZAPAR MAUK 20311 LAPPANS RD BOONSBORO MD 21713</b>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 6 1996</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Page 3

NO. 1012 2011 2 079 101 101 101 101 101

101 101 101 101 101 101 101


asp ITEMS: 23 PART I, 27, 28a-f, Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.  
State of Maryland / Department of Health and Mental Hygiene

PER MEO FILM G-735 5/10/96 t.t

## Certificate of Death

Reg. No.

96 04824

|   |  |   |   |   |  |
|---|--|---|---|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>ESTHER RICHARDSON</b>   |   | 2. Date of Death<br>Month <b>JAN</b> Day <b>31</b> Year <b>1996</b>   |   | 3. Time of Death<br><b>1:15 A</b>  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>6431 JONES CORNER RD.</b>   |   | 4b. City, Town, or Location of Death<br><b>DENTON</b>   |   | 4c. County of Death<br><b>CAROLINE</b>   |
| Funeral<br>Director                           | 5. Social Security Number<br><b>214-30-9117</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>63 Yrs.</b>  | If Under 1 Year<br>Months Days          | If Under 24 Hrs.<br>Hours Min.   |
|   | 8. Date of Birth (Month, Day, Year)<br><b>May 3, 1932</b>  |   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |   |  |
| To Be Completed by Funeral Director           | Usual Residence of Decedent  |   |   |   |  |
|   | 10a. State<br><b>Maryland</b>  | 10b. County<br><b>Caroline</b>  | 10c. City, Town or Location<br><b>Denton</b>  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
|   | 10e. Street and Number<br><b>6431 Johns Corner Rd.</b>   |   | 10f. Zip Code<br><b>21629</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7th</b> College (1-4or 5+)   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Laborer</b>   |   | 16b. Kind of Business/Industry<br><b>Poultry</b>   |
|   | 17. Father's Name (First, Middle, Last)<br><b>Harvey Smith</b>   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Viola Fletcher</b>  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Jessie L. Richardson</b>  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6431 Johns Corner Rd, Denton, Md. 21629</b>   |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Washington Cemetery</b>  |   | Date <b>2/5/96</b> 20c. Location - City or Town, State<br><b>Hurlock, Md.</b>  |
|   | 21. Signature of Funeral Service Licensee<br>  |   | 22. Name and Address of Facility<br><b>Bennie Smith Funeral Home<br/>P.O. Box 1687, Easton, Maryland 21601</b>  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |   |   |   |  |
| Physician<br>/Medical<br>Examiner             | Immediate Cause (Final disease or condition resulting in death)<br><b>SMOKE INHALATION AND THERMAL INJURIES</b>  |   |   |   | Approximate Interval Between Onset and Death   |
|   | Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  |   |   |   |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
|   |  |   |   |   | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |
|   |  |   |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |
|   | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |
|   | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)<br><b>1/30/96</b>  | 28b. Time of Injury<br><b>10:45 P M</b> | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
|   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>HOME</b>  |   | 28d. Describe how injury occurred<br><b>DWELLING FIRE</b>   |   |  |
|   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>6431 JONES CORNER RD. DENTON, MARYLAND</b>  |   |   |   |  |
|   | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   |   |  |
|   | 29b. Signature and title of certifier<br>   |   | 29c. License number<br><b>O.C.M.E</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>JANUARY 31, 1996</b>   |
|   | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>David R Fowler 111 Penn Street, Baltimore, Maryland 21201</b>   |   |   |   |  |
| State<br>Registrar                            | 31. Date filed (Month, Day, Year)<br><b>FEB 07 1996</b>  |   | 32. Registrar's Signature<br>  |   |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 04825

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Richard Allen Rexroth

2. Date of Death

Month Day Year  
Feb 12 1996

3. Time of Death

8:20 a.m.

4a. Facility Name (If not institution, give street and number)

5565 Hilltop Road

4b. City, Town, or Location of Death

La Plata

4c. County of Death

Charles

Funeral  
Director

5. Social Security Number

213-84-9265

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

33 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Nov. 14, 1962

9. Birthplace (State or Foreign Country)

Wash. DC

Usual Residence of Decedent

10a. State

MD

10b. County

Charles

10c. City, Town or Location

LaPlata

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

5565 Hilltop Rd.

10f. Zip Code

20646

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Glazier

16b. Kind of Business/Industry

Glass Industry

17. Father's Name (First, Middle, Last)

Charles Kenneth Rexroth

18. Mother's Name (First, Middle, Maiden Surname)

Ruth Catherine Barnes Rexroth

19a. Informant's Name/Relationship (Type, Print)

Catherine Rexroth

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5565 Hilltop Rd. LaPlata, MD 20646

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Ignatius Cem.

Date

2/14/96

20c. Location - City or Town, State

Hilltop, MD

21. Signature of Funeral Service Licensee

*David C. Echols*

MO0945

22. Name and Address of Facility

AREHART-ECHOLS FUNERAL HOME, INC.

P.O. Box 567 LaPlata, MD 20646

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Testicular Cancer With Metastasis

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other: ☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

*Krishan M. Mathur*

29c. License number

D28352

29d. Date signed (Month, Day, Year)

2/13/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Krishan Mathur, MD

31. Date filed (Month, Day, Year)

FEB 13 1996

32. Registrar's Signature

*Julia Anderson-Randall*

State  
Registrar

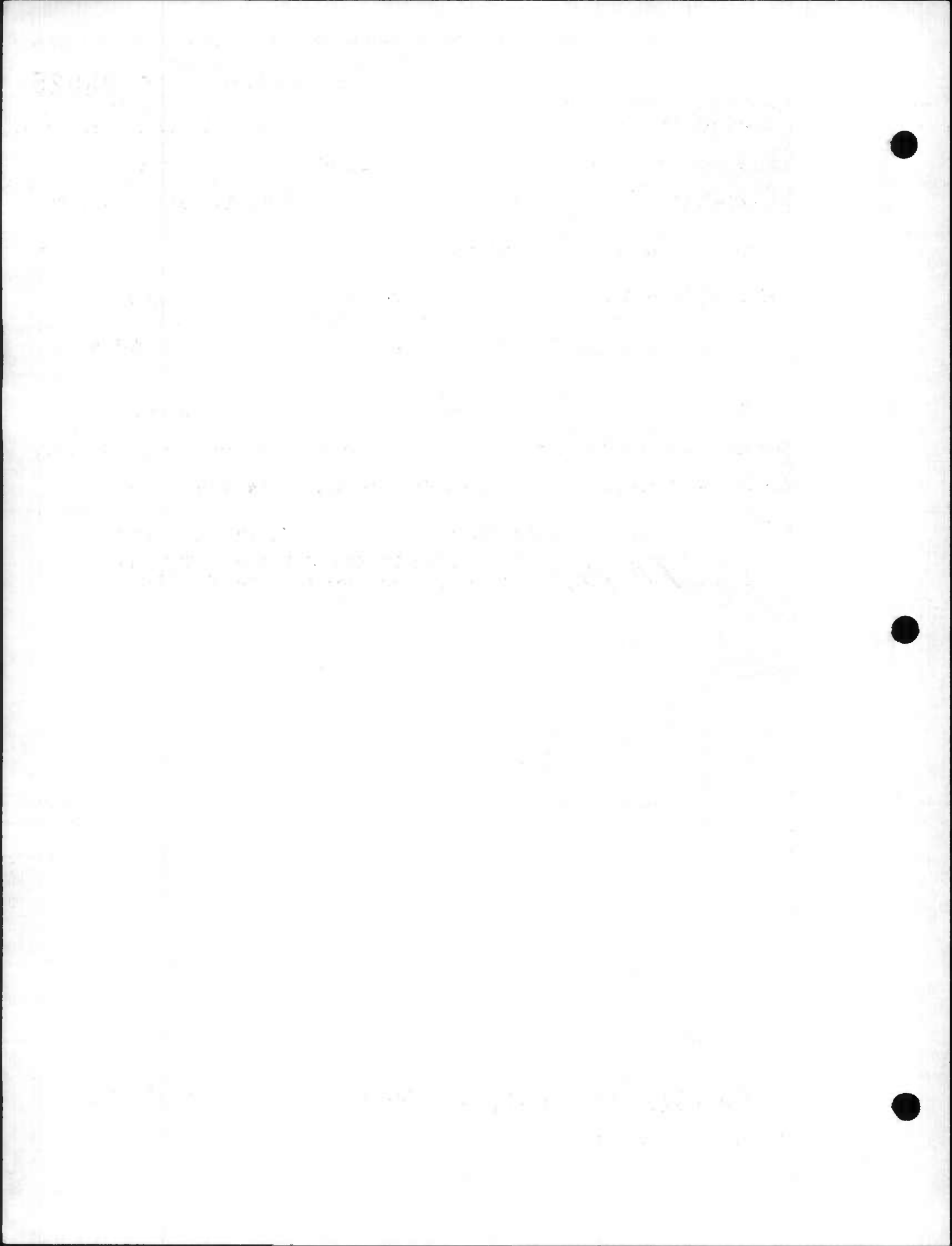
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director  
To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 96 04826

|  |   |                               |   |  |   |  |  |  |  |  |
|--|---|-------------------------------|---|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br>Lillian K Richardson  |                               |   |  |   |  | 2. Date of Death<br>Month Day Year<br>January 31 1996  |  | 3. Time of Death<br>6:45 PM  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>North Arundel Hospital  |                               |   |  |   |  | 4b. City, Town, or Location of Death<br>Glen Burnie  |  | 4c. County of Death<br>Anne Arundel  |  |
| Funeral<br>Director  | 5. Social Security Number<br>220-14-9020  |                               | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>84 Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br>February 24 1911  |  | 9. Birthplace (State or Foreign Country)<br>Maryland   |  |
|  | Usual Residence of Decedent   |                               |   |  |   |  |  |  |  |  |
| To Be Completed by Funeral Director                                  | 10a. State<br>MD  |                               | 10b. County<br>Anne Arundel   |  | 10c. City, Town or Location<br>Glen Burnie  |  |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
|  | 10e. Street and Number<br>7885 Gordon Court   |                               |   |  | 10f. Zip Code<br>21060  |  | 10g. Citizen of What Country?<br>USA   |  |  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |                               | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: white |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+)   |                               |   |  | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Dry Cleaner   |  |  | 16b. Kind of Business/Industry<br>Dry Cleaning                   |  |  |
| To Be Completed by Physician/Medical Examiner                        | 17. Father's Name (First, Middle, Last)<br>Unknown Kellenbach   |                               |   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Jennie Unknown  |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>POLLY BRINK   |                               |   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1844 John Drive, Edgewood, MD 21040 |  |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |                               | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Glen Burnie Cem   |  | 20c. Location - City or Town, State<br>2-5-96 Glen Burnie, MD   |  |  |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br>   |                               |   |  | 22. Name and Address of Facility<br>Buracco and Sons Funeral Home<br>Severna Park, MD 21146   |  |  |  |  |  |
| Physician<br>/Medical<br>Examiner                                    | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. Acute congestive heart failure<br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |                               |   |  |   |  |  |  |  |  |
|  | Approximate Interval Between Onset and Death<br>5 days  |                               |   |  |   |  |  |  |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Ischemic Cardiomyopathy<br>Chronic ventricular atrial arrhythmia<br>Renal failure, anemia   |                               |   |  |   |  |  |  |  |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |                               |   |  |   |  |  |  |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |                               | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |  |  |  |  |  |
|  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |                               | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |  |  |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |                               | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred  |  |
|  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |                               | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |  |  |  |
| State Registrar  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |                               |   |  |   |  |  |  |  |  |
|  | 29b. Signature and title of certifier<br>M.D.   |                               |   |  | 29c. License number<br>047423   |  | 29d. Date signed (Month, Day, Year)<br>January - 31 - 96   |  |  |  |
|  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>Ali Saifi, North Arundel Hospital, 301 Hospital Drive, Glen Burnie MD 21061   |                               |   |  |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>FEB 09 1996                     |   | 32. Registrar's Signature<br> |   |  |   |  |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR  |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 96 04827   |  |                                   |  |
|---|--|--|--|---|--|--|--|--|--|-----------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)  |  |  |  | 2. DATE OF DEATH  |  |  |  | 3. TIME OF DEATH   |  |                                   |  |
| ANTHONY BRIAN ROBERTS   |  |  |  | FEB. 4, 1996  |  |  |  | 07:00AM M  |  |                                   |  |
| 4. SOCIAL SECURITY NUMBER   |  | 5. SEX   |  | 6. AGE (In yrs. last birthday)  |  | IF UNDER 1 YEAR                                |  | IF UNDER 24 HRS.   |  | 7. DATE OF BIRTH                  |  |
| 267-32-3812   |  | 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                       |  | 68 YRS.   |  | MONTHS DAYS HOURS MIN.                         |  |  |  | DEC. 23, 1927                     |  |
| 9a. FACILITY NAME (If not institution, give street and number)  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH   |  |  |  | 9c. COUNTY OF DEATH  |  |                                   |  |
| 8021 DIVIDING CREEK ROAD  |  |  |  | POCOMOKE  |  |  |  | SOMERSET   |  |                                   |  |
| RESIDENCE OF DECEDENT   |  |  |  | 10c. CITY, TOWN OR LOCATION   |  |  |  | 10d. INSIDE CITY LIMITS?   |  |                                   |  |
| 10a. STATE  |  | 10b. COUNTY  |  | POCOMOKE  |  |  |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO      |  |                                   |  |
| MARYLAND  |  | SOMERSET   |  |   |  |  |  |  |  |                                   |  |
| 10e. STREET AND NUMBER  |  |  |  | 10f. ZIP CODE   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?  |  |                                   |  |
| 8021 DIVIDING CREEK ROAD  |  |  |  | 21851   |  |  |  | U.S.   |  |                                   |  |
| 11. MARITAL STATUS  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN?  |  | 14. RACE — American Indian, Black, White, etc. |  |  |  |                                   |  |
| 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married  |  | 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                    |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | Specify: WHITE                                 |  |  |  |                                   |  |
| 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | IF YES, GIVE WAR OR DATES<br>WWII  |  |   |  |  |  |  |  |                                   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |  |  |  |  |                                   |  |
| Elementary/Secondary (0-12)   |  | College (1-4 or 5 +)   |  | FURNACE OPERATOR  |  | ALUMINUM                                       |  |  |  |                                   |  |
| 12  |  |  |  |   |  |  |  |  |  |                                   |  |
| 17. FATHER'S NAME (First, Middle, Last)   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)   |  |  |  |  |  |                                   |  |
| BROOKLYN ROBERTS  |  |  |  | OLGA CHEPAITIS  |  |  |  |  |  |                                   |  |
| 19a. INFORMANT'S NAME (Type/Print)  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)   |  |  |  |  |  |                                   |  |
| HELEN E. ROBERTS  |  |  |  | 8021 DIVIDING CREEK ROAD, POCOMOKE CITY, MD. 21851  |  |  |  |  |  |                                   |  |
| 20a. METHOD OF DISPOSITION  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)                            |  | DATE  |  | 20c. LOCATION — City or Town, State            |  |  |  |                                   |  |
| 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State   |  | MD. VETERANS CEMETERY  |  | 2/7   |  | HURLOCK, MD.                                   |  |  |  |                                   |  |
| 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  |   |  |  |  |  |  |                                   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE   |  |  |  | 22. NAME AND ADDRESS OF FACILITY  |  |  |  |  |  |                                   |  |
| MOO295  |  |  |  | HINMAN FUNERAL HOME<br>PRINCESS ANNE, MARYLAND 21853  |  |  |  |  |  |                                   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |  |  |   |  |  |  | Approximate interval between Onset and Death                                 |  |                                   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →   |  |  |  |   |  |  |  |  |  |                                   |  |
| a. <u>ADENOCARCINOMA OF LUNG</u>  |  |  |  |   |  |  |  |  |  |                                   |  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |  |  |  |  |                                   |  |
| b. <u>HEMORRHOIDS</u>   |  |  |  |   |  |  |  |  |  |                                   |  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |  |  |  |  |                                   |  |
| c. <u>DIABETES</u>  |  |  |  |   |  |  |  |  |  |                                   |  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |  |  |  |  |                                   |  |
| d. _____  |  |  |  |   |  |  |  |  |  |                                   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |  |  |  |  |                                   |  |
| 24a. WAS AN AUTOPSY PERFORMED?  |  |  |  |   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  |  |                                   |  |
| 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |   |  |  |  | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                 |  |                                   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |  |   |  |  |  |  |  |                                   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?  |  |  |  | 26. PLACE OF DEATH (Check only one)   |  |  |  |  |  |                                   |  |
| 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |                                   |  |
| 27. MANNER OF DEATH   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY                            |  | 28c. INJURY AT WORK?   |  | 28d. DESCRIBE HOW INJURY OCCURRED |  |
| 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |  |  |  |   |  | M  |  | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                 |  |                                   |  |
|   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |  |                                   |  |
|   |  |  |  |   |  |  |  |  |  |                                   |  |
| 29a. CERTIFIER (Check only one)   |  |  |  | 29c. LICENSE NUMBER   |  |  |  | 29d. DATE SIGNED (Month, Day, Year)  |  |                                   |  |
| 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  | 024964  |  |  |  | 2/5/96   |  |                                   |  |
| 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |  |  |  |                                   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER   |  |  |  |   |  |  |  |  |  |                                   |  |
|   |  |  |  |   |  |  |  |  |  |                                   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)   |  |  |  |   |  |  |  |  |  |                                   |  |
| R. Little, C. SITOUM ALLEN my Market Street, Pocomoke, Md 21851   |  |  |  |   |  |  |  |  |  |                                   |  |
| 31. DATE FILED (Month, Day, Year)   |  |  |  | 32. REGISTRAR'S SIGNATURE   |  |  |  |  |  |                                   |  |
| FEB 05 1996   |  |  |  |   |  |  |  |  |  |                                   |  |

Form 21

100-100000-100000

100-100000-100000

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR  |  |  |   | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 96 04828  |  |   |  |   |  |
|--|--|--|---|--|--|---|--|---|--|---|--|---|--|
| CERTIFICATE OF DEATH   |  |  |   | REG. NO.   |  |   |  |   |  |   |  |   |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br>EARL A REDDISH   |  |  |   | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>01 30 96   |  |   |  | 3. TIME OF DEATH<br>0440 M  |  |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br>214-30-9533   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br>61 YRS. | 7. DATE OF BIRTH (Month, Day, Year)<br>02-10-34  |  | 8. BIRTHPLACE (State or Foreign Country)<br>MD.   |  |   |  |   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>PENINSULA REGIONAL MEDICAL CENTER  |  |  |   | 9b. CITY, TOWN OR LOCATION OF DEATH<br>SALISBURY   |  |   |  | 9c. COUNTY OF DEATH<br>WICOMICO   |  |   |  |   |  |
| 10a. STATE<br>MD.  |  | 10b. COUNTY<br>WICOMICO  |   | 10c. CITY, TOWN OR LOCATION<br>SALISBURY   |  |   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO       |  |   |  |   |  |
| 10e. STREET AND NUMBER<br>605 SOUTH KAYWOOD AVENUE   |  |  |   | 10f. ZIP CODE<br>21801   |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |   |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>ARMY |   | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>WHITE                                   |  |   |  |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>6  |  | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>TEACHER                                |   | 16b. KIND OF BUSINESS/INDUSTRY<br>PUBLIC SCHOOL  |  |   |  |   |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>JOHN S. REDDISH   |  |  |   | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>EDNA BELLE BENNETT  |  |   |  |   |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>SUZANNE REDDISH  |  |  |   | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>605 SOUTH KAYWOOD AVENUE, SALISBURY, MD. 21801  |  |   |  |   |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>REDDISH FAMILY CEMETERY 2/2                                       |   | 20c. LOCATION — City or Town, State<br>SALISBURY, MD.  |  |   |  |   |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Gerald C. Bounds</i>   |  |  |   | 22. NAME AND ADDRESS OF FACILITY<br>BOUNDS FUNERAL HOME, SALISBURY, MD. 21801  |  |   |  |   |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |   |  |  |   |  | Approximate Interval Between Onset and Death  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |   |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |   | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |   | 28b. TIME OF INJURY<br>M   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |   |  |
|  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |   |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                |  |   |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |   |  |  |   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>John T. Bulkeley, M.D., M.P.H.</i>                        |  | 29c. LICENSE NUMBER<br>D03599   |  | 29d. DATE SIGNED (Month, Day, Year)<br>01-30-96 |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>JOHN T. BULKELEY, M.D., 108 PINE BLUFF ROAD, SALISBURY, MD 21801  |  |  |   |  |  |   |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>JAN 31 1996   |  |  |   | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson Randall</i>  |  |   |  |   |  |   |  |   |  |



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04829

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Jacob Scott Reisinger</i>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><i>Jan 21 1996</i>   |  | 3. TIME OF DEATH<br><i>14:20 M</i>   |  |
| 4. SOCIAL SECURITY NUMBER<br><i>184-16-0519</i>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><i>79</i> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><i>Dec. 24, 1916</i>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><i>Pennsylvania</i>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><i>2460 Bear Den Rd.</i>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Frederick</i>  |  |
| 9c. COUNTY OF DEATH<br><i>Frederick</i>   |  |  |  | 10a. STATE<br><i>Maryland</i>  |  | 10b. COUNTY<br><i>Frederick</i>  |  |
| 10c. CITY, TOWN OR LOCATION<br><i>Frederick</i>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><i>2460 Bear Den Rd.</i>   |  |
| 10f. ZIP CODE<br><i>21701</i>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>United States</i>  |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><i>W.W. II</i>  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>White</i>  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i></i>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><i>Reservation office</i>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>United Airlines</i>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Jacob Fraizer Reisinger</i>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Florence Flickinger</i>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Lillian Ann Reisinger</i>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>2460 Bear Den Rd./ Frederick, Md. 21701</i>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Garrison Forest Veterans 1/25</i>  |  | 20c. LOCATION — City or Town, State<br><i>Owings Mills, Maryland</i>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Raymond Petersen</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>Stauffer Funeral Home<br/>40 Fulton Ave./ Walkersville, Md. 21793</i>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><i>a. Probable hypercalcemia</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><i>b. extensive small cell (ca 10%)</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><i>c.</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><i>d.</i> |  |  |  |  |  |  |  |
| 24. Approximate interval Between Onset and Death<br><i>470</i>  |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>   |  |  |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><i>M</i>  |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>   |  |  |  | 29c. LICENSE NUMBER<br><i>D14626</i>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>Jan 21, 1996</i>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>PG Trausch MD 501 W Seavath St Frederick MD 21701</i>   |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><i>JAN 31 1996</i>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |  |  |





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR  |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 96 04830   |  |
|---|--|--|--|---|--|---|--|--|--|
| CERTIFICATE OF DEATH  |  |  |  | REG. NO.  |  |   |  |  |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ELMER FRANCIS RODGERS</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Jan. 21, 1996</b>  |  |   |  | 3. TIME OF DEATH<br><b>9:38 P M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>220-26-5788</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>64</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>May 23, 1931</b>                                  |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>                                  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Frederick Memorial Hospital</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Frederick</b>   |  |   |  | 9c. COUNTY OF DEATH<br><b>Frederick</b>  |  |
| 10a. STATE<br><b>Maryland</b>   |  |  |  | 10b. COUNTY<br><b>Frederick</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Thurmont</b>  |  | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>7204 Blue Mountain Road</b>  |  |  |  | 10f. ZIP CODE<br><b>21788</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>Korea</b> |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                     |  |  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Laborer</b>                                 |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Construction</b>   |  |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Elmer Wesley Rodgers</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Carrie Frances Myers</b>  |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mary H. Rodgers</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7204 Blue Mountain Road, Thurmont, Maryland 21788</b>   |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, mortuary or other place)<br><b>Resthaven Memorial Gardens 1/24</b>                                     |  | 20c. LOCATION — City or Town, State<br><b>Frederick, Maryland</b>   |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>ROBERT E. DAILEY &amp; SON FUNERAL HOMES, P.A.<br/>615 EAST MAIN STREET, THURMONT, MD 21788</b>  |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Shock</b><br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST {<br>a. <b>Hypotension</b><br>b. <b>Bradycardia</b><br>c. <b>Hyper Kalemia</b><br>d. <b>ESRD</b><br><b>DIABETES mellitus</b><br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b> |  |  |  |   |  |   |  | Approximate Interval Between Onset and Death<br><b>1hr</b><br><b>3hr</b>                     |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> DCA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>MD   |  | 29c. LICENSE NUMBER<br><b>129591</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>1/24/96</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Mark P. Rubin, MD 56 Thomas Johnson Drive, Frederick, Maryland 21701</b>  |  |  |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>JAN 26 1996</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |   |  |  |  |






TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within \_\_\_\_\_ hours after death. Page 6 may be retained by the hospital or attending physician.

1 - FOR  
STATE  
REGISTER

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04831

|   |  |  |  |   |  |   |  |  |  |   |  |   |  |   |  |
|---|--|--|--|---|--|---|--|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>CLINTON POWELL REDDEN</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Feb. 4, 1996</b>   |  |   |  | 3. TIME OF DEATH<br><b>12:14 PM</b>  |  |   |  |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>217 16 9560</b>   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>74</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS.<br>HOURS MIN.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Sept. 28, 1921</b>  |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>10106 Old Ocean City Blvd.</b>   |  |  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Berlin</b>  |  |  |  |   |  | 9c. COUNTY OF DEATH<br><b>Worcester</b>   |  |   |  |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |   |  |  |  |   |  |   |  |   |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Worcester</b>  |  |   |  | 10c. CITY, TOWN OR LOCATION<br><b>Berlin</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |   |  |   |  |
| 10e. STREET AND NUMBER<br><b>10106 Old Ocean City Blvd.</b>   |  |  |  |   |  | 10f. ZIP CODE<br><b>21811</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                       |  |   |  |   |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  |   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                             |  |   |  |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+) <b>College</b>  |  |  |  | 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Waterman</b>   |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Seafood</b>                                     |  |   |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Walter Scott Redden</b>   |  |  |  |   |  | 16. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Minnie Elsie Grey</b>   |  |  |  |   |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Yvonne Evelyn Hastings</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Rt. 3, Box 290 Frankford, DE 19945</b>  |  |   |  |  |  |   |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Evergreen Cemetery 2/7/96</b>   |  |   |  | 20c. LOCATION — City or Town, State<br><b>Berlin, Maryland</b>                       |  |   |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Burbage Funeral Home 108 Williams St. Berlin, MD 21811</b>   |  |   |  |  |  |   |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CONGESTIVE HEART FAILURE</b><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { <b>ISCHEMIC CARDIOMYOPATHY</b><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  |   |  |  |  |   |  | Approximate Interval Between Onset and Death<br><b>5 yrs</b><br><b>5 yrs</b>                              |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CORONARY ARTERY DISEASE, Atrial fib.</b>   |  |  |  |   |  |   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  |   |  |   |  |  |  |   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |   |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |  |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><br><b>RONALD P. TRAUTZ MD</b>  |  |  |  |   |  | 29c. LICENSE NUMBER<br><b>D36576</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>2/5/96</b>                                 |  |   |  |   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>RONALD P. TRAUTZ MD SALISBURY MD 21801</b>  |  |  |  |   |  |   |  |  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 05 1996</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>  |  |   |  |  |  |   |  |   |  |   |  |



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 96 04832  |  |
|---|--|--|--|---|--|---|--|
|   |  | CERTIFICATE OF DEATH   |  |   |  | REG. NO.  |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>FREDERICK MATTHESIUS SPIEGEL</b>   |  | 2. DATE OF DEATH<br>MONTH <b>2</b> DAY <b>5</b> YEAR <b>96</b>   |  | 3. TIME OF DEATH<br><b>6:10 A</b> M   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216-05-1338</b>   | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday)<br><b>81</b> YRS.   | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Sept. 25, 1914</b> | 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Williamsport Nursing Home</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Williamsport</b>   |  | 9c. COUNTY OF DEATH<br><b>Washington</b>  |  |   |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Baltimore</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>10006 Lodge Road</b>   |  | 10f. ZIP CODE<br><b>21234</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WWII</b>  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                         |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+) <b></b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Cabinet Maker</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Lumber Company</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Frederick John Spiegel</b>  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Hilma Helene Matthesius</b>  |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>LeAnne M. Araki</b>  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>10006 Lodge Road, Baltimore, MD. 21234</b>   |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Greenlawn Memorial Park Feb. 7, 1996</b>   |  | 20c. LOCATION — City or Town, State<br><b>Williamsport, MD.</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>OSBORNE FUNERAL HOME<br/>P.O. BOX #348 Williamsport, MD. 21795</b>  |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>MAIGNANT CARDIAC ARRHYTHMIA</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  | Approximate Interval Between Onset and Death<br><b>MINUTES</b>  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>SENILE DEMENTIA</b>  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
|   |  | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>  |  | 29c. LICENSE NUMBER<br><b>D33700</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>2-5-96</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>TED E. HOWE 7542 OVERLOOK DR. BOONSBORO, MD 21713</b>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 7 1996</b>  |  | 32. REGISTRAR'S SIGNATURE<br>  |  |   |  |   |  |



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR  |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 96 04833  |  |   |  |
|--|--|--|--|---|--|---|--|---|--|---|--|
| CERTIFICATE OF DEATH   |  |  |  | REG. NO.  |  |   |  |   |  |   |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>PEARL CATHERINE SNIVELY</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>2</b> DAY <b>4</b> YEAR <b>96</b>  |  | 3. TIME OF DEATH<br><b>3:25P</b> M  |  |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>212-24-3247</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br><b>85</b> YRS. | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>  | IF UNDER 24 HRS.<br>HOURS <b></b> MIN. <b></b> | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Sept. 22 1910</b>                                  |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Williamsport Nursing Home</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Williamsport</b>  |  | 9c. COUNTY OF DEATH<br><b>Washington</b>  |  |   |  |   |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Washington</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Hagerstown</b>  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |   |  |   |  |
| 10e. STREET AND NUMBER<br><b>15229 National Pike</b>   |  |  |  | 10f. ZIP CODE<br><b>21740</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                      |  |   |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>6</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Teacher</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>School System</b>  |  |   |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>George J. Rhodes</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Annie Elizabeth Carbaugh</b>  |  |   |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Lynn R. Snively</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>11322 Vurgoyne Drive Houston, Texas 77077</b>   |  |   |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Rose Hill Cemetery 2-7-96</b>  |  | DATE<br><b></b>   |  | 20c. LOCATION — City or Town, State<br><b>Hagerstown, Maryland</b>                              |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Scott M. Munnick</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Minnich Funeral Home<br/>415 E. Wilson Blvd. Hagerstown, Md. 21740</b>   |  |   |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. PNEUMONIA</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |   |  | Approximate Interval Between Onset and Death<br><b>2 WEEKS</b>  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>ADVANCED MULTI-INFARCT DEMENTIA</b>   |  |  |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |  |   |  |   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
|  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                          |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>J. Howie MD</b>  |  |  |  |   |  | 29c. LICENSE NUMBER<br><b>D33700</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>2-5-96</b>  |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>TED E. HOWE 7542 OVERLOOK DRIVE, BOONSBORO, MD 21713</b>   |  |  |  |   |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 6 1996</b>   |  | 32. REGISTRAR'S SIGNATURE<br><b>J. Snively</b>   |  |   |  |   |  |   |  |   |  |





Shank Naomi Ruth

3035936545

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04834

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Naomi Ruth Shank

2. Date of Death

Month

Day

Year

3. Time of Death

P. M.

4e. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

Funeral  
Director

5. Social Security Number

214-09-3933

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

96

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Oct. 15, 1899

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Washington

10c. City, Town or Location

Smithsburg

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

13 Maple Ave. P.O. Box 143

10f. Zip Code

21783

10g. Citizen of What Country?

U.S.A

11. Marital Status

☐ Never Married ☐ Married  
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Wholesale Co.

17. Father's Name (First, Middle, Last)

Alvey Scott Kuhn

18. Mother's Name (First, Middle, Maiden Surname)

Emma Fharst

19a. Informant's Name/Relationship (Type, Print)

William J. Wivell

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

49 E. Water St. Smithsburg, Md. 21783

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Smithsburg Cemetery Feb. 7, 1996

Date

20c. Location - City or Town, State

Smithsburg, Md.

21. Signature of Funeral Service Licensee

Doris A. Zing

22. Name and Address of Facility

Davis Funeral Home 12525 Bradbury Ave.  
Smithsburg, Md. 21783

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Alzheimer's Dementia

Approximate Interval Between Onset and Death

&gt;5 years

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Chronic Obstructive Pulmonary Disease

&gt;5 years

c. Malnutrition

3-4 months

d. Cerebral Vascular Accidents

Years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Doris A. Zing

29c. License number

D45472

29d. Date signed (Month, Day, Year)

February 4, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dwayne Shuhart MD 22411 Jefferson Blvd Smithsburg Maryland

31. Date filed (Month, Day, Year)

FEB 6 1996

32. Registrar's Signature

J. A. Shank

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR   |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 96 04835  |  |  |  |   |  |
|---|--|--|--|---|--|--|--|---|--|--|--|---|--|
| CERTIFICATE OF DEATH  |  |  |  | REG. NO.  |  |  |  |   |  |  |  |   |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>EDNA VIRGINIA SINCLAIR</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>FEB. 3 1996</b>  |  |  |  | 3. TIME OF DEATH<br><b>9:35 AM</b>  |  |  |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>219-14-3548</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>71</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>MAR. 4, 1924</b> |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>MARYLAND</b> |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>93 PARK LANE, HYDE PARK</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>EASTON</b>  |  |  |  | 9c. COUNTY OF DEATH<br><b>TALBOT</b>  |  |  |  |   |  |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |  |  |   |  |  |  |   |  |
| 10a. STATE<br><b>MARYLAND</b>   |  | 10b. COUNTY<br><b>TALBOT</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>EASTON</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |   |  |
| 10e. STREET AND NUMBER<br><b>93 PARK LANE, HYDE PARK</b>  |  |  |  | 10f. ZIP CODE<br><b>21601</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |  |  |   |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>1944-1947</b>  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  |  |  |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b><br>College (1-4 or 5+) <b></b>   |  | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>POSTMASTER</b>  |  |   |  | 15b. KIND OF BUSINESS/INDUSTRY<br><b>POSTAL SYSTEM</b>                               |  |   |  |  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>HENRY PRICE SINCLAIR</b>  |  |  |  | 16. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>AMELIA FRANCES SHOCKLEY</b>   |  |  |  |   |  |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>VALERIE K. FISHER</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4071 WHITE ROAD, FEDERALSBURG, MD 21632</b>   |  |  |  |   |  |  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>OXFORD CEMETERY</b>  |  | DATE<br><b>2-7</b>  |  | 20c. LOCATION — City or Town, State<br><b>OXFORD, MD 21654</b>                       |  |   |  |  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>JOHN R. MERCERON CFS</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>FELLOWS, HELFENBEIN &amp; NEWMAN F.H., P.A.<br/>200 S. HARRISON ST., EASTON, MD</b>  |  |  |  |   |  |  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Arteriosclerotic Cardiovascular Disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  | Approximate Interval Between Onset and Death<br><b>Years</b>  |  |  |  |   |  |  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |  |  |   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |  |   |  |  |  |   |  |  |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |   |  |  |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Nomicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE NOW INJURY OCCURRED   |  |  |  |   |  |
|   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)         |  |   |  |  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>L. THOMAS DIVILIO</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D24769</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>2/7/96</b>       |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>L. THOMAS DIVILIO, M.D., 404 MARVEL COURT, EASTON, MD 21601</b>   |  |  |  |   |  |  |  |   |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 08 1996</b>   |  | 32. REGISTRAR'S SIGNATURE<br><b>John Andrew Randall</b>  |  |   |  |  |  |   |  |  |  |   |  |



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR   |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 96 04836  |  |   |  |
|--|--|--|--|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)   |  |  |  | 2. DATE OF DEATH   |  |   |  | 3. TIME OF DEATH  |  |   |  |
| Beatrice M. Stiles   |  |  |  | February 11, 1996  |  |   |  | 1920 M  |  |   |  |
| 4. SOCIAL SECURITY NUMBER  |  | 5. SEX   |  | 6. AGE (In yrs. last birthday)   |  | 7. DATE OF BIRTH  |  | 8. BIRTHPLACE (State or Foreign Country)  |  |   |  |
| 376-24-4027  |  | 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                 |  | 79 YRS.  |  | April 16 1916   |  | Michigan  |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH  |  |   |  | 9c. COUNTY OF DEATH   |  |   |  |
| 400 Marley Road  |  |  |  | Elkton   |  |   |  | Cecil   |  |   |  |
| RESIDENCE OF DECEDENT  |  |  |  |  |  |   |  |   |  |   |  |
| 10a. STATE   |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION  |  | 10d. INSIDE CITY LIMITS?  |  |   |  |   |  |
| Maryland   |  | Cecil  |  | Elkton   |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |   |  |   |  |
| 10e. STREET AND NUMBER   |  |  |  | 10f. ZIP CODE  |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?   |  |   |  |
| 400 Marley Road  |  |  |  | 21921  |  |   |  | U.S.A.  |  |   |  |
| 11. MARITAL STATUS   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN?   |  | 14. RACE — American Indian, Black, White, etc.                          |  |   |  |   |  |
| 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>Specify:  |  | Specify: White  |  |   |  |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)   |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |
| Elementary/Secondary (0-12) 10 College (1-4 or 5+) 10  |  |  |  | Homemaker  |  |   |  | n/a   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)  |  |   |  |   |  |   |  |
| Paul J. Mersino  |  |  |  | Mary A. Boza   |  |   |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)  |  |   |  |   |  |   |  |
| Donna B. Strianese   |  |  |  | 400 Marley Road - Elkton, MD 21921   |  |   |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)                      |  | 20c. LOCATION — City or Town, State  |  |   |  |   |  |   |  |
| 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | Gilpin Manor Memorial Park 1996  |  | Elkton, Maryland   |  |   |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  |  |  |  | 22. NAME AND ADDRESS OF FACILITY   |  |   |  |   |  |   |  |
| <i>Donna B. Strianese</i>  |  |  |  | Hicks Home for Funerals, P.A.<br>103 W. Stockton St., Elkton, MD 21921-5521  |  |   |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |  |  |   |  | Approximate Interval Between Onset and Death  |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  |  |  |  |  |   |  |   |  |   |  |
| a. Aortic Stenosis<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |   |  |   |  |   |  |
| b. Type II DM<br>DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |   |  |   |  |   |  |
| c. Atherosclerotic dis<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |   |  |   |  |   |  |
| d.   |  |  |  |  |  |   |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>  |  |  |  |  |  |   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)  |  |   |  |   |  |   |  |
|  |  |  |  | HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |   |  |
| 27. MANNER OF DEATH  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                      |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
| 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |  |  |  |  |  | M   |  |   |  |   |  |
|  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                              |  |   |  |
|  |  |  |  |  |  |   |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)  |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER  |  |   |  |   |  |   |  |
| 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  | <i>Jose Ma, M.D.</i>   |  |   |  |   |  |   |  |
| 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |  |   |  |   |  |   |  |
|  |  |  |  | 29c. LICENSE NUMBER  |  |   |  | 29d. DATE SIGNED (Month, Day, Year)   |  |   |  |
|  |  |  |  | D44716   |  |   |  | 2/12/96   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  |  |  |  |  |  |   |  |   |  |   |  |
| Jose Ma, M.D. 111 W. High Street, Elkton, MD. 21921  |  |  |  |  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)  |  |  |  | 32. REGISTRAR'S SIGNATURE  |  |   |  |   |  |   |  |
| FEB 13 1996  |  |  |  | <i>Julia Davidson-Randall</i>  |  |   |  |   |  |   |  |



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR   |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | CERTIFICATE OF DEATH  |  |  |  | REG. NO. 96 04867                              |  |  |  |
|--|--|--|--|---|--|---|--|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Raymond Augustus Stine, Sr.  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>February 6, 1996  |  |   |  | 3. TIME OF DEATH<br>11:06 A M   |  |  |  |  |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br>214-18-8069   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>78 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  | IF UNDER 24 HRS.<br>HOURS MIN.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>Aug. 8, 1917 |  | 8. BIRTHPLACE (State or Foreign Country)<br>MD |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Physicians Memorial Hospital   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>La Plata   |  |   |  | 9c. COUNTY OF DEATH<br>Charles  |  |  |  |  |  |  |  |
| RESIDENCE OF DECEDENT  |  |  |  | 10c. CITY, TOWN OR LOCATION<br>Newburg  |  |   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |  |  |  |  |  |  |
| 10a. STATE<br>MD   |  | 10b. COUNTY<br>Charles   |  | 10e. STREET AND NUMBER<br>13396 Hill Rd.  |  |   |  | 10f. ZIP CODE<br>20664  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                |  |  |  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White  |  |   |  |  |  |  |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 9<br>College (1-4 or 5+)   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Water Main. Specialist  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Water Treatment   |  |   |  |   |  |  |  |  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Augustus Stine  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Maria Lacey Stine  |  |   |  |   |  |  |  |  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Raymond Stine, Jr.   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>Box 441 Cobb Island, MD 20625  |  |   |  |   |  |  |  |  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of place, cemetery, etc.)<br>Holy Ghost Cem. 2/9/96   |  | 20c. LOCATION — City or Town, State<br>Issue, MD  |  |   |  |   |  |  |  |  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>David C. Echols MO0945  |  | 22. NAME AND ADDRESS OF FACILITY<br>AREHART-ECHEOLS FUNERAL HOME, INC.<br>P.O. Box 567 LaPlata, MD 20646   |  |   |  |   |  |   |  |  |  |  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. <i>Subarachnoid hemorrhage</i><br>b. <i>Cardiogenic Shock</i><br>c. <i>Diabetic Mellitus</i><br>d. <i>Hypertension</i> |  |  |  | Approximate Interval Between Onset and Death  |  |   |  |   |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |   |  |  |  |  |  |  |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  |   |  |   |  |   |  |  |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |   |  |  |  |  |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  |  |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |  |   |  |  |  |  |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |   |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>George Wathen</i>  |  | 29c. LICENSE NUMBER<br>D20624  |  | 29d. DATE SIGNED (Month, Day, Year)<br>2/6/96   |  |   |  |   |  |  |  |  |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>George Wathen, MD, 11345 Pembroke Square Suite 104, Waldorf, Maryland 20603   |  |  |  |   |  |   |  |   |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>FEB 09 1996   |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Shuler Randall</i>   |  |   |  |   |  |   |  |  |  |  |  |  |  |





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
**IMPORTANT:** If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR  |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 96 04838  |  |   |  |
|--|--|--|--|--|--|--|--|---|--|---|--|
| CERTIFICATE OF DEATH   |  |  |  | REG. NO.   |  |  |  |   |  |   |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br>James Lesly Saunders   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>February 7, 1996   |  |  |  | 3. TIME OF DEATH<br>9:19 P M  |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br>220-16-8486   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>70 YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>August 7, 1925                                |  | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>13045 Saunders Marina Place  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Cobb Island   |  |  |  | 9c. COUNTY OF DEATH<br>Charles  |  |   |  |
| 10a. STATE<br>Maryland   |  |  |  | 10b. COUNTY<br>Charles   |  | 10c. CITY, TOWN OR LOCATION<br>Cobb Island   |  |   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br>13045 Saunders Marina Place  |  |  |  | 10f. ZIP CODE<br>20625   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>WW II |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                  |  |   |  |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>10 College (1-4 or 5+)   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Marina Contractor & Operator   |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Constuction/Nautical  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Wilbur Wesly Saunders   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Janie Fish Sanner Saunders  |  |  |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Florence M. Saunders   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>13045 Saunders Marina Place Cobb Island, MD 20625   |  |  |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Christ Church Cemetery 2/10   |  | DATE<br>2/10   |  | 20c. LOCATION — City or Town, State<br>Wayside, Maryland                             |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>M00817<br>Arehart-Echols Funeral Home, Inc.<br>P.O. Box 567 La Plata, MD 20646  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Arehart-Echols Funeral Home, Inc.<br>P.O. Box 567 La Plata, MD 20646   |  |  |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. Respiratory Arrest<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. widespread metastatic prostate carcinoma<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |  |  |  |  | Approximate interval Between Onset and Death  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>  |  |  |  |  |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28b. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>[Signature]   |  |  |  | 29c. LICENSE NUMBER<br>D22807   |  | 29d. DATE SIGNED (Month, Day, Year)<br>2/9/96   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>EDUARD GERMAN / GEORGETOWN UNIVERSITY / 3800 PETERBORO RD NW / WASHINGTON DC 20057  |  |  |  | 31. DATE FILED (Month, Day, Year)<br>FEB 12 1996   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson Randall   |  |   |  |

0-3000 27

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 04839  
2030

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Olive Manning Stocks

2. Date of Death

February 6, 1996

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Calvert Memorial Hospital

4b. City, Town, or Location of Death

Prince Frederick

4c. County of Death

Calvert

5. Social Security Number

246 40 7493

8. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct. 6, 1910

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Calvert

10c. City, Town or Location

Prince Frederick

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

256 Fair Grounds Road, Apt. 256

10f. Zip Code

20678

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

housewife

16b. Kind of Business/Industry

own home

17. Father's Name (First, Middle, Last)

Oel Columbus Manning

18. Mother's Name (First, Middle, Maiden Surname)

Lena Meeks

19a. Informant's Name/Relationship (Type, Print)

Mrs. Phyllis J. Smith / daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4808 S. Polling House Rd., Harwood, MD 20776

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

So. Mem. Gardens

Date

02/09/96

20c. Location - City or Town, State

Dunkirk, MD 20754

21. Signature of Funeral Service Licensee

William R. H.

22. Name and Address of Facility

Rausch Funeral Home, P.A., Owings, MD 20736

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. INCARCERATED HIATAL HERNIA

Approximate Interval Between Onset and Death

12 Hours

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

AORTIC REGURGITATION

MITRAL REGURGITATION

CONGESTIVE HEART FAILURE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

John M. H.

29c. License number

D 40370

29d. Date signed (Month, Day, Year)

2/6/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Prince Frederick

31. Date filed (Month, Day, Year)

FEB - 9 1996

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 96 04840

|  |   |  |  |                                      |   |  |   |   |
|--|---|--|--|--------------------------------------|---|--|---|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Darrell Lee Showell   |  |  |                                      | 2. Date of Death<br>Month Day Year<br>01 29 96  |  | 3. Time of Death<br>1:50A   |   |
|  | 4a. Facility Name (If not institution, give street and number)<br>(Home) 102 Spruce Street  |  |  |                                      | 4b. City, Town, or Location of Death<br>Fruitland   |  | 4c. County of Death<br>Wicomico   |   |
| Funeral<br>Director  | 5. Social Security Number<br>219-56-778   |  | 6. Sex<br>1 Male 2 Female<br>2 F   | 7. Age (In yrs. last birthday)<br>42 | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.                 | 8. Date of Birth (Month, Day, Year)<br>February 28, 1953                    | 9. Birthplace (State or Foreign Country)<br>MD  |
|  | Usual Residence of Decedent   |  |  |                                      |   |  |   |   |
| To Be Completed by Funeral Director  | 10a. State<br>MD  |  | 10b. County<br>Wicomico  |                                      | 10c. City, Town or Location<br>Fruitland  |  | 10d. Inside City Limits<br>1 Yes 2 No                                       |   |
|  | 10e. Street and Number<br>102 Spruce Street   |  |  |                                      | 10f. Zip Code<br>21826  |  | 10g. Citizen of What Country?<br>U.S.A.                                     |   |
|  | 11. Marital Status<br>1 Never Married 2 Married 3 Widowed 4 Divorced<br>2 Married   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 Yes 2 No<br>2 No  |                                      | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 Yes 2 No Specify:     |  | 14. Race - American Indian, Black, White, etc.<br>Specify:<br>AFRO-AMERICAN |   |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) UNKNOWN   |  | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>TRUCK DRIVER               |                                      | 16b. Kind of Business/Industry<br>CON-AGRA  |  |   |   |
| To Be Completed by Physician/Medical Examiner  | 17. Father's Name (First, Middle, Last)<br>Charles William Showell  |  |  |                                      | 18. Mother's Name (First, Middle, Maiden Surname)<br>Louise M. McGregor   |  |   |   |
|  | 19a. Informant's Name (Relationship (Type, Print))<br>Doris Showell   |  |  |                                      | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>102 Spruce Street - Fruitland Md 21826 |  |   |   |
|  | 20a. Method of Disposition<br>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Springhill Memory Gardens                                    |                                      | 20c. Location - City or Town, State<br>Nebron, Md   |  | 20d. Date<br>2/5  |   |
|  | 21. Signature of Funeral Service Licensee<br>[Signature]  |  | 22. Name and Address of Facility<br>Williamson-Fluharty Fun Soc<br>917 W. Isabella St Salisbury, Md                                    |                                      |   |  |   |   |
| Physician<br>/Medical<br>Examiner  | 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>a. Multi-system organ failure<br>Due to (or as a consequence of):<br>b. Renal cell carcinoma, metastatic to<br>Due to (or as a consequence of):<br>c. lung and liver<br>Due to (or as a consequence of):<br>d. |  |  |                                      |   |  |   | Approximate Interval Between Onset and Death<br>1 week                                    |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |                                      |   |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 Yes 2 No 3 Probably 4 Unknown |
|  | 24a. Was an autopsy performed?<br>1 Yes 2 No  |  |  |                                      |   |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 Yes 2 No |
|  | 25. Was case referred to medical examiner?<br>1 Yes 2 No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) |                                      |   |  |   |   |
| 27. Manner of Death<br>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)               |  | 28b. Time of Injury<br>M             |   | 28c. Injury at Work?<br>1 Yes 2 No             |   | 28d. Describe how injury occurred   |
| 29a. Certifier (Check only one)<br>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and Title of certifier<br>[Signature] |  | 29c. License number<br>D42975        |   | 29d. Date signed (Month, Day, Year)<br>1/29/96 |   |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Michael A. Carducci MD 600 N. Wolfe ST RM 126 ONC, Baltimore MD 21287  |   |  |  |                                      |   |  |   |   |
| 31. Date filed (Month, Day, Year)<br>FEB 05 1996   |   | 32. Registrar's Signature<br>Julia Anderson Randall  |  |                                      |   |  |   |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

01870 20

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A.2.11

AFRO-AMERICAN

MD Wisconsin  
102 Spruce Street  
x  
Fruitland  
81850  
x

x

x

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04841

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><u>Diane Joyce Simmons</u>  |  |  |  | 2. DATE OF DEATH<br>MONTH <u>01</u> DAY <u>19</u> YEAR <u>96</u>   |  | 3. TIME OF DEATH<br><u>1620</u> M   |  |
| 4. SOCIAL SECURITY NUMBER<br><u>218-62-3785</u>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><u>41</u> YRS.   |  | 7. DATE OF BIRTH<br>MONTH <u>01</u> DAY <u>24</u> YEAR <u>1954</u>                                  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><u>Atlantic General Hospital</u>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><u>Berlin</u>   |  | 9c. COUNTY OF DEATH<br><u>WORCESTER</u>   |  |
| 10a. STATE<br><u>MD</u>   |  | 10b. COUNTY<br><u>WICOMICO</u>   |  | 10c. CITY, TOWN OR LOCATION<br><u>SALISBURY</u>  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><u>602-B Goldsborough Street</u>  |  |  |  | 10f. ZIP CODE<br><u>21801</u>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR OATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><u>AFRO-AMERICAN</u>                  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>12</u><br>College (1-4 or 5+) <u>UNKNOWN</u>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><u>CASHIER</u>                  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><u>SUPER GIANT</u>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><u>JAMES WILSON, SR</u>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><u>IDA BAILEY</u>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><u>DONALD EDMONDS</u>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>602-B Goldsborough Street - Salisbury, MD</u>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><u>CAPITAL CREMATORY SERV</u>                                 |  | DATE <u>2/22</u>   |  | 20c. LOCATION — City or Town, State<br><u>DOVER, DE</u>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><u>[Signature]</u>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><u>WILLIAMSON - FULHARTY FUN SIC</u><br><u>917 W. ISABELLA ST - SALISBURY, MD 21801</u>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>AIDS</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <u>Wasting Syndrome</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |  |  |  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  |
| 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><u>[Signature]</u>   |  |  |  | 29c. LICENSE NUMBER<br><u>H43617</u>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><u>1/19/96</u>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)<br><u>11220 Beauchamp Rd Berlin MD 21811</u>   |  |  |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><u>FEB 05 1996</u>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |  |   |  |

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1 - FOR STATE REGISTRAR  |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 96 04842  |  |   |  |  |  |   |  |
|--|--|--|--|--|--|--|--|---|--|---|--|--|--|---|--|
| CERTIFICATE OF DEATH   |  |  |  | REG. NO.   |  |  |  |   |  |   |  |  |  |   |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br>BARBARA JUNE Smith   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>February 3, 1996   |  |  |  | 3. TIME OF DEATH<br>1:33 PM   |  |   |  |  |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br>218-40-5499   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>52 YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>APR. 21, 1943                                 |  | 8. BIRTHPLACE (State or Foreign Country)<br>MD.   |  |   |  |  |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>PENINSULA REGIONAL MEDICAL CENTER  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>SALISBURY   |  |  |  | 9c. COUNTY OF DEATH<br>WICOMICO   |  |   |  |  |  |   |  |
| 10a. STATE<br>MD.  |  |  |  | 10b. COUNTY<br>WORCESTER   |  | 10c. CITY, TOWN OR LOCATION<br>SNOW HILL   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |   |  |  |  |   |  |
| 10e. STREET AND NUMBER<br>4008 PAW PAW CREEK ROAD  |  |  |  | 10f. ZIP CODE<br>21863   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |   |  |  |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>WHITE                  |  |   |  |   |  |  |  |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>HOUSEWIFE  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>OWN HOME   |  |   |  |   |  |  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>RUSSELL E. TRUITT   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>ELSIE TAYLOR  |  |  |  |   |  |   |  |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>HARRY J. SMITH   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4008 PAW PAW CREEK ROAD, SNOW HILL, MD. 21863   |  |  |  |   |  |   |  |  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>PITTSVILLE CEMETERY 2/6                                       |  | 20c. LOCATION — City or Town, State<br>PITTSVILLE, MARYLAND  |  |  |  |   |  |   |  |  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Gerald C. Bruner  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>BOUNDS FUNERAL HOME, SALISBURY, MD. 21804  |  |  |  |   |  |   |  |  |  |   |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic Cancer Unknown Primary<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequently ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |  |  |  |  |   |  | Approximate Interval Between Onset and Death<br>2 weeks   |  |  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>End Stage Cirrhosis of the Liver   |  |  |  |  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>  |  |  |  |  |  |  |  |   |  |   |  |  |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |   |  |   |  |  |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |  |  |   |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |   |  |   |  |  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |  |  |   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>MD   |  | 29c. LICENSE NUMBER<br>D 26278   |  | 29d. DATE SIGNED (Month, Day, Year)<br>2-4-96 |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>David Connell, MD 115 E. Carroll St Salisbury, MD 21801   |  |  |  |  |  |  |  |   |  |   |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>FEB 05 1996   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>John Alexander Randall  |  |  |  |   |  |   |  |  |  |   |  |

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04843

|   |  |   |  |  |  |   |                                |   |  |   |  |
|---|--|---|--|--|--|---|--------------------------------|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Ervin Smith   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>Feb 8 1996   |  | 3. TIME OF DEATH<br>1:15 P M  |                                |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br>212-12-8334  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>74 YRS.  |  | 7. DATE OF BIRTH<br>MONTH DAY YEAR<br>Nov 16 1921   |                                | 8. BIRTHPLACE (State or Foreign Country)<br>W.Va  |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Garrett Co Mem. Hospital  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Oakland   |  |   | 9c. COUNTY OF DEATH<br>Garrett |   |  |   |  |
| RESIDENCE OF DECEDENT   |  |   |  | 10c. CITY, TOWN OR LOCATION<br>Blaine  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |                                |   |  |   |  |
| 10a. STATE<br>W.Va  |  | 10b. COUNTY<br>Mineral  |  | 10e. STREET AND NUMBER<br>General Delivery   |  | 10f. ZIP CODE<br>21538  |                                | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                                    |                                |   |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 5<br>College (1-4 or 5+)  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Coal Miner                         |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Coal   |  |   |                                |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Charles Smith  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Minnie Harvey   |  |   |                                |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Andrew Smith  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>General Delivery Kitzmiller, Md 21538   |  |   |                                |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Kaibaug Cemetery Feb. 11 96                                      |  | 20c. LOCATION — City or Town, State<br>Elk Garden W.Va   |  |   |                                |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>David A. Burdock   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>David A. Burdock Funeral Home<br>PO Box 523 Kitzmiller, Md 21538   |  |   |                                |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CORONARY ARTERY DISEASE<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |  |  |   |                                | Approximate Interval Between Onset and Death<br>17 year   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  |   |                                | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |  |  |   |                                |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |                                |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |                                | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |                                |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |  |  |   |                                |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Karl Schwalm   |  |   |  | 29c. LICENSE NUMBER<br>D27205  |  | 29d. DATE SIGNED (Month, Day, Year)<br>2/9/96   |                                |   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Karl Schwalm 311 N 4th St. Oakland, Md 21550   |  |   |  |  |  |   |                                |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>FEB 12 1996  |  |   |  | 32. REGISTRAR'S SIGNATURE<br>Julia Anderson-Rodriguez  |  |   |                                |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.




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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |   |                                     |  | 96 04844  |  |
|---|--|--|--|---|--|---|---|-------------------------------------|--|---|--|
| 1 - FOR STATE REGISTRAR   |  |  |  |   |  |   |   |                                     |  | REG. NO.  |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>SELMA SARAH SIMON</b>  |  |  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>FEBRUARY</b> DAY <b>9</b> YEAR <b>1996</b> |   | 3. TIME OF DEATH<br><b>6:00 P M</b> |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>220-54-7137</b>   |  | 5. SEX<br><b>1 M 2 F</b>   | 6. AGE (In yrs. last birthday)<br><b>97</b> YRS. | 7. DATE OF BIRTH (Month, Day, Year)<br><b>APR. 25, 1898</b>   |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>MARYLAND</b>             |   |                                     |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>CUPPETT &amp; WEEKS NURSING HOME</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>OAKLAND</b>   |  | 9c. COUNTY OF DEATH<br><b>GARRETT</b>                                   |   |                                     |  |   |  |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |   |   |                                     |  |   |  |
| 10a. STATE<br><b>MARYLAND</b>   |  | 10b. COUNTY<br><b>CARROLL</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>SYKESVILLE</b>  |  |   | 10d. INSIDE CITY LIMITS?<br><b>1 X YES 2 NO</b>                         |                                     |  |   |  |
| 10e. STREET AND NUMBER<br><b>unknown</b>  |  |  |  | 10f. ZIP CODE<br><b>21784</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                             |   |                                     |  |   |  |
| 11. MARITAL STATUS<br><b>1 X Never Married 2 Married 3 Widowed 4 Divorced</b>   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 YES 2 X NO</b><br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 YES 2 X NO</b> Specify:       |  |   | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b> |                                     |  |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>unknown</b> College (1-4 or 8+) <b>unknown</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>unknown</b>                      |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>unknown</b>                        |   |                                     |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>unknown</b>   |  |  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>unknown</b>     |   |                                     |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>CUPPETT &amp; WEEKS NURSING HOME</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7TH &amp; ALDER STREETS OAKLAND, MD 21550</b> |  |   |   |                                     |  |   |  |
| 20a. METHOD OF DISPOSITION<br><b>1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>OAKLAND CEMETERY</b>   |  | DATE<br><b>2/14</b>   |  | 20c. LOCATION — City or Town, State<br><b>OAKLAND, MARYLAND</b>         |   |                                     |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br> <b>M00167</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>P.O. BOX 243 DURST FUNERAL HOME - OAKLAND, MD 21550</b>  |  |   |   |                                     |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>pneumonia</b><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |   |   |                                     |  | Approximate Interval Between Onset and Death<br><b>1 week</b> |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>atherosclerotic cardiovascular disease, dementia</b>   |  |  |  |   |  |   |   |                                     |  | 24a. WAS AN AUTOPSY PERFORMED?<br><b>1 YES 2 X NO</b>         | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1 YES 2 NO</b> |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  |   |  |   |   |                                     |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1 YES 2 X NO</b>   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> OTHER: <b>4 X Nursing Home 5 Residence 6 Other (Specify)</b> |  |   |  |   |   |                                     |  |   |  |
| 27. MANNER OF DEATH<br><b>1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined</b>   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><b>1 YES 2 NO</b>                               |   | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |   |                                     |  |   |  |
| 29a. CERTIFIER (Check only one)<br><b>1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b><br><b>2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>   |  |  |  |   |  |   |   |                                     |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br> <b>M.D.</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D25759</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>February 9, 1996</b>          |   |                                     |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Walter K. Naumann, M.D., P.O. Box 247, 106 cemetery Rd., Accident MD 21520</b>  |  |  |  |   |  |   |   |                                     |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 15 1996</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>                                  |  |   |   |                                     |  |   |  |



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04845

|  |  |  |  |  |  |  |   |   |  |   |  |
|--|--|--|--|--|--|--|---|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Eva Kathern SEAL   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>Feb. 12, 1996  |  | 3. TIME OF DEATH<br>M  |   |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br>234-58-0090   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>76 YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>Apr. 27, 1919                                 |   | 8. BIRTHPLACE (State or Foreign Country)<br>West Virginia   |  |   |  |
| 9a. FACILITY NAME (If not Institution, give street and number)<br>Garrett County Memorial Hospital   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Oakland   |  |  | 9c. COUNTY OF DEATH<br>Garrett  |   |  |   |  |
| RESIDENCE OF DECEDENT  |  |  |  |  |  |  |   |   |  |   |  |
| 10a. STATE<br>MD   |  | 10b. COUNTY<br>Garrett   |  | 10c. CITY, TOWN OR LOCATION<br>Mt. Lake Park   |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |  |   |  |
| 10e. STREET AND NUMBER<br>607 P Street   |  |  |  | 10f. ZIP CODE<br>21550   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |   |   |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                                 |   |  |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8th<br>College (1-4 or 5+) College  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Housewife  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Home  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Walter Early Arnold   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Elsie Alice King  |  |  |   |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Esther Clemons   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>P.O. Box 33, Oakland, Maryland 21550  |  |  |   |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Accident Cemetery   |  | DATE<br>2/14   |  | 20c. LOCATION — City or Town, State<br>Horseshoe Run, WV                             |   |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Bradley A. Howard   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Stewart Funeral Home<br>32 S. Second St., Oakland, MD 21550  |  |  |   |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Myocardial Infarction.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |  |  |  |   | Approximate Interval Between Onset and Death<br>Sudden  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Congestive Heart Failure.  |  |  |  |  |  |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |  |  |  |  |   |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |   |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |   |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |  |   |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Dr. Robert Goralski, MD   |  |  |  | 29c. LICENSE NUMBER<br>D23979  |  | 29d. DATE SIGNED (Month, Day, Year)<br>2/12/96                                       |   |   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Dr. Robert Goralski, MD 311 N. Fourth St., Oakland, Maryland 21550  |  |  |  |  |  |  |   |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>FEB 16 1996   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>John Anderson   |  |  |   |   |  |   |  |

6407



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 96 01846

|   |  |  |   |  |   |   |  |  |
|---|--|--|---|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Frances Chaney Summers   |  |   |  | 2. Date of Death<br>Month Day Year<br>January 20 1996   |   | 3. Time of Death<br>4:36 a.m.  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Frederick Memorial Hospital  |  |   |  | 4b. City, Town, or Location of Death<br>Frederick   |   | 4c. County of Death<br>Frederick   |  |
| Funeral<br>Director   | 5. Social Security Number<br>212-03-3028   |  | 8. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>79 Yrs.              | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.                          | 8. Date of Birth (Month, Day, Year)<br>Aug 12, 1916  | 9. Birthplace (State or Foreign Country)<br>Maryland |
|   | Usual Residence of Decedent  |  |   |  |   |   |  |  |
| To Be Completed by Funeral Director   | 10a. State<br>Maryland   |  | 10b. County<br>Frederick  |  | 10c. City, Town or Location<br>Frederick  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|   | 10e. Street and Number<br>1001 Carroll Parkway, Apt. 405   |  |   |  | 10f. Zip Code<br>21701  |   | 10g. Citizen of What Country?<br>U.S.A.  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                 |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 11 College (1-4or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Sales Person   |   | 16b. Kind of Business/Industry<br>Retail Store   |  |
|   | 17. Father's Name (First, Middle, Last)<br>Harvey BUTLER   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Otie Estelle SNOOTS  |   |  |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br>Alden B. Summers, Jr (Son)   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2250 S Gessner Rd, #613, Houston, Texas 77063  |   |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Mt. Olivet Cemetery   |  | Date<br>Jan 24, 1996  |   | 20c. Location - City or Town, State<br>Frederick, MD   |  |
|   | 21. Signature of Funeral Service Licensee<br><i>Kathleen Robinson</i> M00706   |  |   |  | 22. Name and Address of Facility<br>Keeney & Basford P.A. Funeral Home<br>106 E Church St, Frederick, Maryland 21701  |   |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Lung Cancer Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of): |  |   |  |   |   |  |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown<br>24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |  |   |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>pneumonia</i>  |  |  |   |  |   |   |  |  |
| State Registrar   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 28. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  |   |   |  |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M  |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No             |  |
|   | 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |   |  |   |   |  |  |
| 29b. Signature and title of certifier<br><i>Lloyd E. Halvorson</i>  |  |  |   | 29c. License number<br>D22019                          |   | 29d. Date signed (Month, Day, Year)<br>January 22, 1996 |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>Lloyd E. Halvorson, MD, 1475 Taney Avenue, Suite 204, Frederick, Maryland 21702   |  |  |   |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br>JAN 22 1996  |  |  |   | 32. Registrar's Signature<br><i>Lloyd E. Halvorson</i> |   |   |  |  |



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR  |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE             |  |   |  | 96 04847                                  |  |   |  |  |  |   |  |
|---|--|--|--|---|--|---|--|---|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)  |  |  |  | 2. DATE OF DEATH  |  |   |  | 3. TIME OF DEATH                          |  |   |  |  |  |   |  |
| Chalmers L. Shifler Jr.   |  |  |  | Feb. 05, 1996   |  |   |  | 8:00 a. M                                 |  |   |  |  |  |   |  |
| 4. SOCIAL SECURITY NUMBER   |  | 5. SEX   |  | 8. AGE (In yrs. last birthday)  |  | IF UNDER 1 YEAR   |  | IF UNDER 24 HRS.                          |  | 7. DATE OF BIRTH  |  | 6. BIRTHPLACE (State or Foreign Country)                                     |  |   |  |
| 219-10-5999   |  | 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 70 YRS.   |  | MONTHS DAYS   |  | HOURS MIN.                                |  | Sept. 12 1925   |  | MD   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)  |  |  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH   |  |   |  | 9c. COUNTY OF DEATH   |  |  |  |   |  |
| 2118 Woodview Drive   |  |  |  |   |  | Finksburg   |  |   |  | Carroll   |  |  |  |   |  |
| 10a. STATE  |  |  |  | 10b. COUNTY   |  |   |  | 10c. CITY, TOWN OR LOCATION               |  |   |  | 10d. INSIDE CITY LIMITS?   |  |   |  |
| Maryland  |  |  |  | Carroll   |  |   |  | Finksburg                                 |  |   |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO      |  |   |  |
| 10e. STREET AND NUMBER  |  |  |  |   |  | 10f. ZIP CODE   |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?   |  |  |  |   |  |
| 2118 Woodview Drive   |  |  |  |   |  | 21048   |  |   |  | United States   |  |  |  |   |  |
| 11. MARITAL STATUS  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN?                                    |  | 14. RACE — American Indian, Black, White, etc.  |  | 15. DECEDENT'S EDUCATION                  |  | 16a. DECEDENT'S USUAL OCCUPATION  |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |   |  |
| 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married   |  | 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | Specify: White  |  | Elementary/Secondary (0-12)               |  | mail carrier  |  | Postal Service   |  |   |  |
| 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | IF YES, GIVE WAR OR DATES  |  | WWII  |  |   |  | College (1-4 or 5+)                       |  |   |  |  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)   |  |  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)   |  |   |  |   |  |  |  |   |  |
| Chalmers L. Shifler Sr.   |  |  |  |   |  | Ida Florence Hilton   |  |   |  |   |  |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)  |  |  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |  |   |  |   |  |  |  |   |  |
| Stewart L. Shifler  |  |  |  |   |  | 2724 Kildaire Dr., Baltimore, MD 21234  |  |   |  |   |  |  |  |   |  |
| 20a. METHOD OF DISPOSITION  |  | 20b. PLACE AND DATE OF DISPOSITION   |  | 20c. LOCATION — City or Town, State                                     |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE   |  | 22. NAME AND ADDRESS OF FUNERAL HOME      |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. |  | Approximate Interval Between Onset and Death                                 |  |   |  |
| 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State   |  | 2/08/96  |  | Baltimore, MD   |  | Katherine Pisto-Sweet   |  | Dunlavy Funeral Home & Chapel             |  | IMMEDIATE CAUSE (Final disease or condition resulting in death)   |  | MIN  |  |   |  |
| 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | Woodlawn Cemetery  |  |   |  |   |  | 412 Washington Rd., Westminster, MD 21157 |  | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  |  | MIN  |  |   |  |
|   |  |  |  |   |  |   |  |   |  | a. VENTRICULAR FIBRILLATION   |  | YEARS  |  |   |  |
|   |  |  |  |   |  |   |  |   |  | b. ACUTE MYOCARDIAL INFARCTION  |  |  |  |   |  |
|   |  |  |  |   |  |   |  |   |  | c. ARTERIO-SCLEROTIC HEART DISEASE  |  |  |  |   |  |
|   |  |  |  |   |  |   |  |   |  | d.  |  |  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |   |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |  |
|   |  |  |  |   |  |   |  |   |  |   |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO      |  | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  |   |  |   |  |   |  |   |  |  |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?  |  | 26. PLACE OF DEATH (Check only one)  |  |   |  |   |  |   |  |   |  |  |  |   |  |
| 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |   |  |   |  |  |  |   |  |
| 27. MANNER OF DEATH   |  | 28a. DATE OF INJURY  |  | 28b. TIME OF INJURY   |  | 28c. INJURY AT WORK?  |  | 28d. DESCRIBE NOW INJURY OCCURRED         |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |  |   |  |
| 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation  |  | Month, Day, Year   |  | M   |  | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                  |  |   |  |   |  |  |  |   |  |
| 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined  |  |  |  |   |  |   |  |   |  |   |  |  |  |   |  |
| 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  |  |  |   |  |   |  |   |  |   |  |  |  |   |  |
| 29a. CERTIFIER (Check only one)   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER  |  |   |  |   |  |   |  |   |  | 29c. LICENSE NUMBER  |  | 29d. DATE SIGNED (Month, Day, Year)   |  |
| 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                      |  | Lawrence A. Awa  |  |   |  |   |  |   |  |   |  | 200391   |  | 2/6/96  |  |
| 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |   |  |   |  |  |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)   |  |  |  |   |  |   |  |   |  |   |  |  |  |   |  |
| DR LAWRENCE AWA 100 SISTER PIERRE DR. SUITE 207, TOWSON MD 21204  |  |  |  |   |  |   |  |   |  |   |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)   |  |  |  | 32. REGISTRAR'S SIGNATURE   |  |   |  |   |  |   |  |  |  |   |  |
| FEB - 7 1996  |  |  |  | John A. Awa   |  |   |  |   |  |   |  |  |  |   |  |

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 96 01848  
9. Time of Death 12:50 AmPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Lily Stull

2. Date of Death

January 29 1996

3. Time of Death

12:50 Am

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

Funeral  
Director

5. Social Security Number

217-50-1855

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

62 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

November 10, 1933

9. Birthplace (State or Foreign Country)

Tennessee

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Thurmont

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

12709 Layman Road

10f. Zip Code

21788

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: American Indian

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

10

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

self

17. Father's Name (First, Middle, Last)

Bud Brewer

18. Mother's Name (First, Middle, Maiden Surname)

Daisy Garland

19a. Informant's Name/Relationship (Type, Print)

Wanda S. Ardle

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12709 Layman Rd., Thurmont, MD 21788

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Faith U.C.C. Cemetery

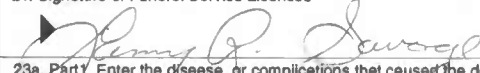
Date

2/1/96

20c. Location - City or Town, State

Charlesville, MD

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Stauffer Funeral Homes, P.A.

1621 Opossumtown Pike, Frederick, MD 21702

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. PNEUMONIA

Due to (or as a consequence of):

b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Days

Years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier



29c. License number

D35152

29d. Date signed (Month, Day, Year)

1-29-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

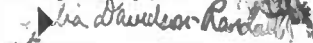
JOC. KRANTZ, MD 100 S. CENTER ST. THURMONT, MD 21788

State  
Registrar

31. Date filed (Month, Day, Year)

JAN 31 1996

32. Registrar's Signature



Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

\_\_\_\_\_

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. DECEDENT'S NAME (First, Middle, Last)  |  |  |  | 2. DATE OF DEATH  |  |   |  | 3. TIME OF DEATH  |  |                     |  |  |  |
|---|--|--|--|---|--|---|--|---|--|---------------------|--|--|--|
| JOSEPH JACKSON SCHUSTER   |  |  |  | MONTH DAY YEAR<br>Jan. 28, 1996   |  |   |  | 7:40 A M  |  |                     |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br>712-14-9142  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>97 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS.<br>HOURS MIN.  |  |                     |  |  |  |
| 7. DATE OF BIRTH<br>(Month, Day, Year)<br>Oct. 23, 1898   |  |  |  | 8. BIRTHPLACE (State or Foreign Country)<br>Yugoslavia  |  |   |  |   |  |                     |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Homewood Retirement Center  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Frederick  |  |   |  | 9c. COUNTY OF DEATH<br>Frederick  |  |                     |  |  |  |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |   |  |   |  |                     |  |  |  |
| 10a. STATE<br>Maryland  |  | 10b. COUNTY<br>Frederick   |  | 10c. CITY, TOWN OR LOCATION<br>Frederick  |  |   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |                     |  |  |  |
| 10e. STREET AND NUMBER<br>Homewood Retirement Center<br>31 West Patrick Street  |  |  |  | 10f. ZIP CODE<br>21701  |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |                     |  |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>WWI  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White  |  |                     |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Court Magistrate  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>None  |  |   |  |   |  |                     |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Peter Schuster   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Katharina Stuhlmuller  |  |   |  |   |  |                     |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Jack F. Mason   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>10412 Pleasant Vista Drive, Frederick, MD 21701  |  |   |  |   |  |                     |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Smithsburg Crematory  |  | DATE<br>1/29  |  | 20c. LOCATION — City or Town, State<br>Smithsburg, Maryland                                 |  |   |  |                     |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>ROBERT E. DAILEY & SON FUNERAL HOMES, P.A.<br>1201 NORTH MARKET ST. FREDERICK, MD 21701   |  |   |  |   |  |                     |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Diverticulitis</u><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  |   |  | Approximate Interval Between Onset and Death<br>years   |  |                     |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Gastric ulcer</u>  |  |  |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |  |                     |  |  |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  |   |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |                     |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |   |  |                     |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |                     |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |   |  |                     |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  | 29c. LICENSE NUMBER |  | 29d. DATE SIGNED (Month, Day, Year)<br>1/29/96 |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Casper E. Cline III, MD 300 West Ninth Street, Frederick, Maryland 21701   |  |  |  |   |  |   |  |   |  |                     |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>JAN 31 1996  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |   |  |   |  |                     |  |  |  |

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 96 04850

|   |  |                          |   |   |  |  |  |  |
|---|--|--------------------------|---|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>ROBERT EUGENE SHUFF  |                          |   |   | 2. Date of Death<br>Month Day Year<br>JANUARY 26, 1996   |  | 3. Time of Death<br>12:30 p.m.   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Frederick Memorial Hospital  |                          |   |   | 4b. City, Town, or Location of Death<br>Frederick  |  | 4c. County of Death<br>Frederick   |  |
| Funeral<br>Director                           | 5. Social Security Number<br>215-42-4064   |                          | 8. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>51 Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 6. Date of Birth<br>(Month, Day, Year)<br>Aug. 7, 1944                               | 9. Birthplace (State or Foreign Country)<br>Maryland |
|   | Usual Residence of Decedent  |                          |   |   |  |  |  |  |
| To Be Completed by Funeral Director           | 10a. State<br>Maryland   | 10b. County<br>Frederick | 10c. City, Town or Location<br>Walkersville   |   |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |
|   | 10e. Street and Number<br>206 Wellesley Court  |                          |   | 10f. Zip Code<br>21793                    |  | 10g. Citizen of What Country?<br>U.S.A.  |  |  |
| To Be Completed by Physician/Medical Examiner | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |                          | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year Dates: Jan. 63 to Dec 65  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                     |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4or 5+) 12  |                          | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Salesman  |   | 16b. Kind of Business/Industry<br>Ice and Beverage store   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br>Charles William Shuff, Sr.  |                          |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Beatrice M. Long  |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Beatrice M. Shuff - mother   |                          |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>206 Wellesley Court, Walkersville, Md. 21793  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |                          | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Lewistown Cemetery  |   | Date<br>Jan. 30, 1996  | 20c. Location - City or Town, State<br>Lewistown, Maryland   |  |  |
|   | 21. Signature of Funeral Service Licensee<br>Richard C. C. Basford M00021  |                          | 22. Name and Address of Facility<br>Keeney and Basford Funeral Home<br>106 East Church Street, Frederick, Md. 21701   |   |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Severe Chronic Obstructive Pulmonary Disease<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. { Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |                          |   |   |  |  |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Diabetic Mellitus<br>Degenerative Joint Disease<br>Hypertension  |                          |   |   |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |                          |   |   | 24e. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  |
|   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |                          |   |   |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |                          | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |   |  |  |  |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |                          | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred  |                          | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
|   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |                          |   |   |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 29b. Signature and title of certifier<br>James S. Grisson MD   |                          |   |   | 29c. License number<br>D21944  |  | 29d. Date signed (Month, Day, Year)<br>1/26/96                                       |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>JAMES S. GRISSON MD 1475 TANEY AVE SUITE 204 FREDERICK MD 21701  |                          |   |   |  |  |  |  |
| State Registrar                               | 31. Date filed (Month, Day, Year)<br>JAN 29 1996   |                          |   |   | 32. Registrar's Signature<br>Davidson-Randall  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04851

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

|   |  |  |  |   |  |   |   |   |  |
|---|--|--|--|---|--|---|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Bertha Hazel Smith</i>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><i>January 25 1996</i>  |  | 3. TIME OF DEATH<br><i>1230 P M</i>   |   |   |  |
| 4. SOCIAL SECURITY NUMBER<br><i>214-46-9718</i>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><i>80</i> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>April 8, 1915</i>                              |   | 8. BIRTHPLACE (State or Foreign Country)<br><i>Maryland</i>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>Shady Grove Adventist Hospital</i>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Rockville</i>   |  |   | 9c. COUNTY OF DEATH<br><i>Montgomery</i>  |   |  |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |   |   |   |  |
| 10a. STATE<br><i>Maryland</i>   |  | 10b. COUNTY<br><i>Montgomery</i>   |  | 10c. CITY, TOWN OR LOCATION<br><i>Gaithersburg</i>  |  |   | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |   |  |
| 10e. STREET AND NUMBER<br><i>211 Russell Avenue - #105</i>  |  |  |  | 10f. ZIP CODE<br><i>20877</i>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>American</i>  |   |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No - If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  |   | 14. RACE - American Indian, Black, White, etc.<br>Specify: <i>White</i>                         |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><i>Elementary/Secondary (0-12) 12th</i>   |  | 15a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>Homemaker</i>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>Own home.</i>  |  |   |   |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Lewis Duvall</i>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Bertha Watkins</i>  |  |   |   |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Rebecca Norwood</i>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>23831 Woodfield Road, Gaithersburg, Maryland 21882</i>                                    |  |   |   |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Pine Grove Cemetery</i>  |  | DATE<br><i>1/29</i>   |  | 20c. LOCATION - City or Town, State<br><i>Mount Airy, Maryland</i>                          |   |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Olin L. Molesworth</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>Olin L. Molesworth, P.A., Funeral Home<br/>26401 Ridge Road, Damascus, Maryland 20872</i>  |  |   |   |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><i>Myocardial infarction, presumed</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><i>coronary artery disease</i><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><i>diabetes</i><br><i>peripheral vascular disease</i><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>diabetes</i><br><i>peripheral vascular disease</i> |  |  |  |   |  |   |   | Approximate Interval Between Onset and Death<br><i>2 days</i><br><i>years</i>   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |   |  |   |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>   |  |  |  |   |  |   |   |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |   |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><i>M</i>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   | 28d. DESCRIBE NOW INJURY OCCURRED   |  |
| 28e. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |   |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>David A. Blass MD</i>   |  |  |  | 29c. LICENSE NUMBER<br><i>D23911</i>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>January 25 1996</i>                               |   |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>David A. Blass MD 9910 Old Georgetown Rd. Bethesda, Md 20814</i>  |  |  |  |   |  |   |   |   |  |
| 31. DATE FILED (Month, Day, Year)<br><i>JAN 29 1996</i>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John D. ...</i>   |  |   |   |   |  |

12900 25

DMMH-18 Rev 1/89

25 00853

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR  |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 96 04853  |  |  |  |
|--|--|--|--|---|--|---|--|---|--|--|--|
| CERTIFICATE OF DEATH   |  |  |  | REG. NO.  |  |   |  |   |  |  |  |
| 1. DECEASED'S NAME (First, Middle, Last)<br><b>Oscar Tilghman, Jr.</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JAN. 29, 1996</b>  |  | 3. TIME OF DEATH<br><b>10:20 AM</b>   |  |   |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216-18-2276</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br><b>69</b> YRS. | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS.<br>HOURS MIN.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Feb. 4, 1926</b>  |  |  |  |
| 8a. FACILITY NAME (If not institution, give street and number)<br><b>Dorchester General Hospital</b>   |  |  |  | 8b. CITY, TOWN OR LOCATION OF DEATH<br><b>Cambridge</b>   |  | 8c. COUNTY OF DEATH<br><b>Maryland</b>  |  |   |  |  |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Dorchester</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Cambridge</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |   |  |  |  |
| 10e. STREET AND NUMBER<br><b>602-Edgewood Avenue</b>   |  |  |  | 10f. ZIP CODE<br><b>21613</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |  |   |  |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Black</b>                      |  |   |  |  |  |
| 15. DECEASED'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>   |  | 16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Bricklayer's Assist.</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Construction</b>   |  |   |  |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Oscar Tilghman, Sr.</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Beulah Major</b>  |  |   |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Clara B. Tilghman</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>602-Edgewood Ave, Cambridge Maryland 21613</b>  |  |   |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Bethel Cemetery</b>  |  | DATE<br><b>2/3</b>  |  | 20c. LOCATION — City or Town, State<br><b>Cambridge, Maryland</b>                               |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Janelle C. Henry</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Henry Funeral Home</b><br><b>510 Washington St. Cambridge, MD. 21613</b>   |  |   |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → Metastatic Lung Cancer</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>a. _____<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. _____<br>Approximate interval between Onset and Death<br><b>6 mos</b> |  |  |  |   |  |   |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>_____  |  |  |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |  |   |  |   |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |   |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  |
|  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                    |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>M. H. Hadden MD</b>  |  |  |  |   |  | 29c. LICENSE NUMBER<br><b>D26388</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>1-30-96</b>   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Michael Hadden MD 302 Collins Hurlock MD 21643</b>   |  |  |  |   |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 06 1996</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Jane A. Hadden</b>  |  |   |  |   |  |  |  |

पृष्ठ २०



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04854

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Clarence W. Thomas

2. Date of Death

Month 2 Day 11 Year 96

3. Time of Death

8:15 AM

4a. Facility Name (If not institution, give street and number)

University of Maryland Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

----

Funeral  
Director

5. Social Security Number

203-24-8167

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

63

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Aug. 5, 1932

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

PARKTON

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

19835 York Road

10f. Zip Code

21120

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
8

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

Cement Mfg.

17. Father's Name (First, Middle, Last)

Harry N. Thomas

18. Mother's Name (First, Middle, Maiden Surname)

Dorothy I. Wirtz

19a. Informant's Name/Relationship (Type, Print)

Sylvia A. Thomas

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19835 York Rd., Parkton, MD 21120

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Mt. Zion Cemetery

Date

Feb. 14, 1996

20c. Location - City or Town, State

Freeland, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

J.J. Hartenstein Mortuary, Inc.  
24 Second St., New Freedom, PA 1734923a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

Vertebrobasilar Junction Aneurysm

Due to (or as a consequence of):

Subarachnoid Hemorrhage

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending  
investigation  
6 ☐ Could not be  
determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

AU4176435AT2818

29d. Date signed (Month, Day, Year)

2/11/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

225 GREEN ST. BALTIMORE MD, 21201

31. Date filed (Month, Day, Year)

FEB 21 1996

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,


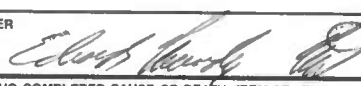
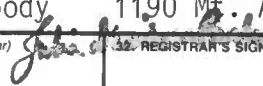


1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

96 04855

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Frances Phelps Thomson   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>February 06 96  |  | 3. TIME OF DEATH<br>12:43 A M   |  |
| 4. SOCIAL SECURITY NUMBER<br>146-22-4373 D   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>89 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>Aug. 3, 1906   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Clearview Nursing Home   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Hagerstown   |  | 9c. COUNTY OF DEATH<br>Washington   |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |  |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Washington  |  | 10c. CITY, TOWN OR LOCATION<br>Big Pool   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>10108 National Pike  |  |  |  | 10f. ZIP CODE<br>21711  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                                    |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2   |  | 15a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Registered Nurse  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Nursing Bryn Mar Hosp.  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Arthur Brooks Phelps  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Mary Booth   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Lawrence E. Reed   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>10108 National Pike Big Pool, MD. 21711  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Smithsburg Crematory Feb. 7, 1996   |  | 20c. LOCATION — City or Town, State<br>Smithsburg, MD.  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>OSBORNE FUNERAL HOME<br>P.O. Box #348 Williamsport, MD. 21795   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Acute Pulmonary Edema</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. <i>Acute Congestive Heart Failure</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <i>Arteriosclerotic Heart Disease</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Approximate Interval Between Onset and Death<br><i>22 hrs</i><br><i>12 hrs</i><br><i>many years</i> |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Heart insufficiency</i><br><i>Chronic brain syndrome with dementia</i>  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO      |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  | 29c. LICENSE NUMBER<br>007857   |  | 29d. DATE SIGNED (Month, Day, Year)<br>2/6/96   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Edson B. Moody 1190 Mt. Aetna Rd. Hagerstown, MD. 21740   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>FEB 7 1996  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

12 10 02

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04856

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

|   |  |   |   |   |  |   |  |  |
|---|--|---|---|---|--|---|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Thomas R. Taylor  |  |   |   | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>Feb. 2, 1996  |  | 3. TIME OF DEATH<br>23:20 M   |  |  |
| 4. SOCIAL SECURITY NUMBER<br>222-01-7930  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  | 6. AGE (In yrs. last birthday)<br>79 YRS. |   | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>Sept. 11, 1916 |   | 8. BIRTHPLACE (State or Foreign Country)<br>Virginia |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>PENINSULA REGIONAL MEDICAL CENTER   |  |   |   | 9b. CITY, TOWN OR LOCATION OF DEATH<br>SALISBURY  |  | 9c. COUNTY OF DEATH<br>WICOMICO   |  |  |
| 10a. STATE<br>Delaware  |  | 10b. COUNTY<br>Sussex   |   | 10c. CITY, TOWN OR LOCATION<br>Millsboro  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |
| 10e. STREET AND NUMBER<br>Route 5, Box 151  |  |   |   | 10f. ZIP CODE<br>19966  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |   | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: Black  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 6th<br>College (1-4 or 5+) College  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Correctional Officer   |   | 16b. KIND OF BUSINESS/INDUSTRY<br>State Employee  |  |   |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Harry Taylor   |  |   |   | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Marcelle Harmons   |  |   |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>J. Thomasina Lewis  |  |   |   | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>463-B Cheswold Blvd, Newark, De. 19713   |  |   |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Old Field Cemetery   |   | 20c. LOCATION — City or Town, State<br>2/10/96 Millsboro, De.   |  |   |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Phyllis A. Prince  |  |   |   | 22. NAME AND ADDRESS OF FACILITY<br>Bennie Smith Funeral Home<br>P.O. Box 1687, Easton, Md. 21601   |  |   |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Myocardial Infarction<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. Atherosclerotic Coronary Artery Disease<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |   |   |   |  | Approximate Interval Between Onset and Death<br>2 hrs.<br>10 yrs.   |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |  |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |   |   |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |  |   |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)  |   | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |   | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Steve Julian MD  |   |   |  |   |  |  |
|   |  | 29c. LICENSE NUMBER<br>D41813   |   | 29d. DATE SIGNED (Month, Day, Year)<br>2/2/96   |  |   |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>J. Steve Julian MD 201 Pine Bluff Rd Salisbury MD 21801  |  |   |   |   |  |   |  |  |
| 31. DATE FILED (Month, Day, Year)<br>FEB 07 1996  |  | 32. REGISTRAR'S SIGNATURE<br>John A. Weller-Randall   |   |   |  |   |  |  |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2205-2

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 04857

|  |  |   |  |  |  |   |   |  |
|--|--|---|--|--|--|---|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>ZOEN NICOLETTE TESTER</b>                       |   |  |  | 2. Date of Death<br>Month <b>2</b> - Day <b>5</b> - Year <b>96</b> |   | 3. Time of Death<br><b>1050 pm</b>                    |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>JOHNS HOPKINS BAYVIEW</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>           |   | 4c. County of Death<br><b>N/A</b>                     |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>220-45-2248</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>0</b> Yrs.                    |   | 8. Date of Birth (Month, Day, Year)<br><b>1-29-96</b> |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>MD</b>  |   | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>A.A.</b>   |   | 10c. City, Town or Location<br><b>Glen Burnie</b>     |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>1236 Cedar Cliff Drive</b>   |  | 10f. Zip Code<br><b>21060</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>   |   |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>   |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>0</b> College (1-4 or 5+) <b>0</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>N/A</b>   |  | 16b. Kind of Business/Industry<br><b>N/A</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>ROBERT L. TESTER JR.</b>  |   |  |
| 18. Mother's Name (First, Middle, Maiden Summa)<br><b>DEBORAH GREEN</b>  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Robert and Deborah Green</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Same as #10</b>  |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                       |   |  |
| 20b. Place of Disposition (Name of cemetery, crematory, or other place)<br><b>Cedar Hill Cem. 28-96</b>  |  | 20c. Location - City or Town, State<br><b>BALT, MD</b>  |  | 21. Signature of Funeral Service Licensee<br><b>Robert S. [Signature]</b>  |  | 22. Name and Address of Facility<br><b>BARBARO Severnark Funeral Home</b>   |   |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Intracranial Hemorrhage</b><br>Due to (or as a consequence of):<br><b>b. Prematurity</b><br>Due to (or as a consequence of):<br><b>c. Respiratory Distress Syndrome</b><br>Due to (or as a consequence of):<br><b>d.</b> |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day, Year)<br><b>28b. Time of Injury<br/>M</b><br><b>28c. Injury at Work?<br/>1 Yes 2 No</b><br><b>28d. Describe how injury occurred</b><br><b>28e. Location (Street and Number or Rural Route Number, City or Town, State)</b> |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. Signature and title of certifier<br><b>G. Alpan M.D.</b>   |  | 29c. License number<br><b>D 42096</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>2/5/96</b>  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>G. ALPAN; NICH; 4940 EASTERN AVE., BALTIMORE</b>  |  | 31. Date filed (Month, Day, Year)<br><b>FEB 09 1996</b>   |  | 32. Registrar's Signature<br><b>[Signature]</b>  |  |   |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 505A.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR  |  |   |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 96 04858  |  |  |  |
|---|--|---|--|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)  |  |   |  | 2. DATE OF DEATH   |  |  |  | 3. TIME OF DEATH  |  |  |  |
| Blanche F. Thurnburg  |  |   |  | January 30 1996  |  |  |  | 12:05 A <sup>m</sup>  |  |  |  |
| 4. SOCIAL SECURITY NUMBER   |  | 5. SEX  |  | 6. AGE (In yrs. last birthday)   |  | 7. DATE OF BIRTH                               |  | 8. BIRTHPLACE (State or Foreign Country)                                |  |  |  |
| 120-32-3706   |  | 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 88 YRS.  |  | March 1, 1907                                  |  | New York  |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH  |  |  |  | 9c. COUNTY OF DEATH   |  |  |  |
| Wicomico Nursing Home   |  |   |  | Salisbury  |  |  |  | Wicomico  |  |  |  |
| 10a. STATE  |  |   |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION                    |  | 10d. INSIDE CITY LIMITS?  |  |  |  |
| Florida   |  |   |  | Volusia  |  | Daytona Beach                                  |  | 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |  |  |
| 10e. STREET AND NUMBER  |  |   |  | 10f. ZIP CODE  |  | 10g. CITIZEN OF WHAT COUNTRY?                  |  |   |  |  |  |
| 1251 Vine St.   |  |   |  | 32117  |  | USA  |  |   |  |  |  |
| 11. MARITAL STATUS  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN?   |  | 14. RACE — American Indian, Black, White, etc. |  |   |  |  |  |
| 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>Specify:  |  | Specify:<br>White                              |  |   |  |  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)  |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |  |  |   |  |  |  |
| Elementary/Secondary (0-12)<br>12   |  | College (1-4 or 5+)<br>2  |  | Bookkeeper   |  | Board of Education                             |  |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)  |  |  |  |   |  |  |  |
| Louis P. Fourcade   |  |   |  | Anna Schoen  |  |  |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)  |  |  |  |   |  |  |  |
| Suzanne F. Erskine  |  |   |  | 420 Elberta Ave., Salisbury, MD 21801  |  |  |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)   |  | DATE   |  | 20c. LOCATION — City or Town, State            |  |   |  |  |  |
| 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | Salisbury Crematory   |  | 1/31   |  | Salisbury, MD                                  |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE   |  |   |  | 22. NAME AND ADDRESS OF FACILITY   |  |  |  |   |  |  |  |
| David H. Thompson   |  |   |  | Holloway Funeral Home<br>501 Snow Hill Rd., Salisbury, Md 21801  |  |  |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |  |  |  |  |  | Approximate Interval Between Onset and Death                            |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →   |  |   |  |  |  |  |  | 4 days  |  |  |  |
| a. Pneumonia - Terminal   |  |   |  |  |  |  |  |   |  |  |  |
| b. Extensive Decub Ulcer  |  |   |  |  |  |  |  | 1 year  |  |  |  |
| c. Immobility   |  |   |  |  |  |  |  | years   |  |  |  |
| d. CVA + Age  |  |   |  |  |  |  |  | year  |  |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  |  |   |  |  |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  |  |  |   |  |  |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |   |  |  |  |  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?  |  | 26. PLACE OF DEATH (Check only one)   |  | 27. MANNER OF DEATH  |  | 28a. DATE OF INJURY (Month, Day, Year)         |  | 28b. TIME OF INJURY   |  | 28c. INJURY AT WORK?   |  |
| 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |  |  |  | M   |  | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 29a. CERTIFIER (Check only one)   |  |   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER  |  |  |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)                          |  |
| 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  | [Signature]  |  |  |  | D02026  |  | 1-3096   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)   |  |   |  |  |  |  |  |   |  |  |  |
| F.G. Arthes, MD 1622 A Ocean Pines, Berlin, Md. 21811   |  |   |  |  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)   |  |   |  | 32. REGISTRAR'S SIGNATURE  |  |  |  |   |  |  |  |
| FEB 01 1996   |  |   |  | John Andrew Randall  |  |  |  |   |  |  |  |

10828

Amended line 7 SED, FCHD as Per Funeral Director  
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 96 04859

|  |   |   |  |   |  |  |  |  |                               |  |  |  |
|--|---|---|--|---|--|--|--|--|-------------------------------|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Ernest George Taubersmith, Jr.                    |   |  |   | 2. Date of Death<br>Month Day Year<br>January 21 1996  |  | 3. Time of Death<br>8:15 a.m.  |  |                               |  |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Frederick Memorial Hospital |   |  |   | 4b. City, Town, or Location of Death<br>Frederick      |  | 4c. County of Death<br>Frederick   |  |                               |  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br>219-42-2816  |   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>67 <sup>11</sup> / <sub>18</sub> Yrs.   | If Under 1 Year<br>Months Days                         | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth<br>(Month, Day, Year)<br>Jan. 10, 1928  | 9. Birthplace (State or Foreign)<br>Columbia District of   |                               |  |  |  |
|  | Usual Residence of Decedent   |   |  |   |  |  |  |  |                               |  |  |  |
| 10a. State<br>Md.  |   | 10b. County<br>Frederick  |  | 10c. City, Town or Location<br>Middletown   |  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |                               |  |  |  |
| 10e. Street and Number<br>300 Franklin St. Apt. C32  |   |   |  | 10f. Zip Code<br>21769  |  | 10g. Citizen of What Country?<br>U.S.A.  |  |  |                               |  |  |  |
| 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S.<br>Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: 1950-1956  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-<br>if Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian,<br>Black, White, etc.<br>Specify: White  |  |  |                               |  |  |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+)   |   |   |  | 18a. Decedent's Usual Occupation<br>(Give kind of work done during most of working<br>life. DO NOT use retired)<br>bookkeeper   |  | 16b. Kind of Business/Industry<br>accounting   |  |  |                               |  |  |  |
| 17. Father's Name (First, Middle, Last)<br>Ernest George Taubersmith Sr.   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Amelia Menhorn   |  |  |  |  |                               |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Virginia A. Lundregan (Sister)   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>7307 Countryside Dr., Middletown, Md. 21769  |  |  |  |  |                               |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of<br>cemetery, crematory or other place)<br>Lutheran Cemetery  |  | Date<br>1/25  | 20c. Location - City or Town, State<br>Middletown, Md. |  |  |  |                               |  |  |  |
| 21. Signature of Funeral Service Licensee<br>  |   |   |  | 22. Name and Address of Facility<br>Donald B. Thompson Funeral Home<br>31 E. Main St., Middletown, Md. 21769  |  |  |  |  |                               |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,<br>shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final<br>disease or condition<br>resulting in death)<br><br>a. Congestive Heart Failure<br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions,<br>if any, leading to immediate<br>cause. Enter Underlying<br>Cause (Disease or injury<br>that initiated events<br>resulting in death) Last |   |   |  |   |  |  |  | Approximate<br>Interval Between<br>Onset and Death   |                               |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |                               |  |  |  |
|  |   |   |  |   |  | 24a. Was an autopsy<br>performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings<br>available prior to<br>completion of cause<br>of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                               |  |  |  |
| 25. Was case referred to medical<br>examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |  |                               |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury<br>(Month, Day, Year)   |  | 28b. Time of<br>Injury<br>M   |  | 28c. Injury at<br>Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 28d. Describe how injury occurred  |                               |  |  |  |
|  |   | 28e. Place of Injury - At home, farm, street, factory, office<br>building, etc. (Specify)   |  |   |  |  |  | 28f. Location (Street and Number or Rural Route Number,<br>City or Town, State)  |                               |  |  |  |
| 29a. Certifier<br>(Check only<br>one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)<br>and manner stated.   |   | 29b. Signature and title of certifier<br>   |  |   |  |  |  |  | 29c. License number<br>D16939 |  | 29d. Date signed (Month, Day, Year)<br>1/21/96 |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Betha Middletown Md 21769  |   |   |  |   |  |  |  |  |                               |  |  |  |
| 31. Date filed (Month, Day, Year)<br>JAN 29 1996   |   | 32. Registrar's Signature<br>   |  |   |  |  |  |  |                               |  |  |  |

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Physician  
/Medical  
Examiner  
To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
certificate.

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director  
To Be Completed by Physician/Medical Examiner

93041

AMENDED #2, #7, 2/5/96, B.P., WORCESTER CO.

96 04860

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>JOSEPH CLIFTON TAYLOR, SR.</b>   |  |  |  | 2. DATE OF DEATH (Month, Day, Year)<br><b>June 27, 1930</b>   |  | 3. TIME OF DEATH<br><b>2:00 A M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>214 28 8607</b>   |  | 5. SEX<br><b>XX M 2 F</b>  |  | 6. AGE (In yrs. last birthday)<br><b>65 YRS.</b>  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Feb. 2, 1996</b>                           |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>   |  |  |  | 9. COUNTY OF DEATH<br><b>Worcester</b>  |  |  |  |
| 10. FACILITY NAME (If not institution, give street and number)<br><b>9927 Old Ocean City Blvd.</b>  |  |  |  | 11. CITY, TOWN OR LOCATION OF DEATH<br><b>Berlin</b>  |  | 12. RESIDENCE OF DECEDENT  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Worcester</b>  |  | 13c. CITY, TOWN OR LOCATION<br><b>Berlin</b>  |  | 13d. INSIDE CITY LIMITS?<br><b>XX YES 2 NO</b>                                       |  |
| 14. STREET AND NUMBER<br><b>9927 Old Ocean City Blvd.</b>   |  |  |  | 15. ZIP CODE<br><b>21811</b>  |  | 16. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 17. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |  | 18. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 19. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 20. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>              |  |
| 21. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6</b><br>College (1-4 or 5+) <b>Dredger</b>   |  | 22. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Waterman</b>   |  | 23. KIND OF BUSINESS/INDUSTRY<br><b>Waterman</b>  |  |  |  |
| 24. FATHER'S NAME (First, Middle, Last)<br><b>Granville George Taylor, Sr.</b>  |  |  |  | 25. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Lucy Elliott</b>  |  |  |  |
| 26. INFORMANT'S NAME (Type/Print)<br><b>Joseph Clifton Taylor, Jr.</b>  |  |  |  | 27. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P.O. Box 303 Bishopville, MD 21813</b>   |  |  |  |
| 28. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 29. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Evergreen Cemetery 2/7/96 Berlin, Maryland</b>  |  | 30. LOCATION — City or Town, State<br><b>108 Williams St. Berlin, MD 21811</b>  |  |  |  |
| 31. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>   |  | 32. NAME AND ADDRESS OF FACILITY<br><b>Burbage Funeral Home 108 Williams St. Berlin, MD 21811</b>  |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>MYOCARDIAL INFARCTION</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>CAD</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>SEQUENTIALLY list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |  |   |  |  |  |
| 33. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 34. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 35. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 36a. DATE OF INJURY (Month, Day, Year)   |  | 36b. TIME OF INJURY<br><b>M</b>   |  | 36c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 36d. DESCRIBE HOW INJURY OCCURRED   |  | 37. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |  |
| 38a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |  |
| 39. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i> <b>C. Holzworth, M.D.</b>  |  |  |  | 40. LICENSE NUMBER<br><b>D06241</b>   |  | 41. DATE SIGNED (Month, Day, Year)<br><b>5-5-96</b>                                  |  |
| 42. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>DOROTHY C. HOLZWORTH 103 SNOW ST SNOW HILL, MD 21763</b>  |  |  |  |   |  |  |  |
| 43. DATE FILED (Month, Day, Year)<br><b>FEB 05 1996</b>   |  |  |  | 44. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1384-27

96 04861

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>GEORGE HARRIS ULARY</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>FEB</b> DAY <b>9</b> YEAR <b>1996</b>   |  | 3. TIME OF DEATH<br><b>0636 AM</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>218 - 26 - 4229</b>   |  | 5. SEX<br><b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>67</b> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>April 15, 1928</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>   |  |   |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>24 Hillcrest Lane</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>North East</b>   |  |
| 9c. COUNTY OF DEATH<br><b>Cecil</b>   |  |   |  | 10a. STATE<br><b>Maryland</b>  |  |  |  |
| 10b. COUNTY<br><b>Cecil</b>   |  |   |  | 10c. CITY, TOWN OR LOCATION<br><b>North East</b>   |  |  |  |
| 10d. INSIDE CITY LIMITS?<br><b>1</b> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  | 10e. STREET AND NUMBER<br><b>24 Hillcrest Lane</b>   |  |  |  |
| 10f. ZIP CODE<br><b>21901</b>   |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>  |  |  |  |
| 11. MARITAL STATUS<br><b>2</b> <input checked="" type="checkbox"/> Married<br><b>3</b> <input type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>12</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Security Department</b>                       |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Credit Card Corporate Office</b>  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Louis B. Ulyar</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Ida Amanda Arrants</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mary B. Ulyar</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>24 Hillcrest Lane, North East, MD 21901</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Reinterment from State<br><b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Hart's Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>2/12 Elk Neck, Maryland</b>  |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>Crouch Funeral Home</b><br><b>127 South Main Street, North East, MD 21901</b>  |  |   |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ASCVD</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br><br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>strong family history of coronary artery disease</b>   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |   |  | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO  |  |  |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DCA<br>OTHER: <b>4</b> <input checked="" type="checkbox"/> Nursing Home <b>5</b> <input checked="" type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify) |  |   |  | 27. MANNER OF DEATH<br><b>1</b> <input checked="" type="checkbox"/> Natural <b>2</b> <input type="checkbox"/> Accident <b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide <b>5</b> <input type="checkbox"/> Pending investigation <b>6</b> <input type="checkbox"/> Could not be determined  |  |  |  |
| 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office, building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. CERTIFIER (Check only one)<br><b>1</b> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>W. Bruce Oberstheim, MD</b>   |  |   |  | 29c. LICENSE NUMBER<br><b>D 35779</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>2/9/96</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>W. Bruce Oberstheim, MD</b><br><b>Emergency Dept. Union Hospital</b>  |  |   |  | 31. DATE FILED (Month, Day, Year)<br><b>FEB 12 1996</b>  |  |  |  |
| 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |  |   |  |  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10840 22



Feb. 2, 1996

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

96 04862

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>EDWARD PURSLEY VICKERS JR.   |  |  |  | 3. DATE OF DEATH<br>MONTH DAY YEAR<br>Feb 2/96  |  | 3. TIME OF DEATH<br>0900 M  |  |
| 4. SOCIAL SECURITY NUMBER<br>213-12-5936   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>73 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>July 25 1922  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Dorchester General Hospital  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Cambridge  |  | 9c. COUNTY OF DEATH<br>Dorchester   |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |  |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Dorchester  |  | 10c. CITY, TOWN OR LOCATION<br>Cambridge  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>1505 Race St.  |  |  |  | 10f. ZIP CODE<br>21613  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>World War II   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: white                                    |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (9-12) 11 College (1-4 or 5+) 11  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>owned and operated dry cleaning business   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Edward Pursley Vickers  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Verene Wirz  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Mrs. Barbara Wozny   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>409 Shepherd Ave. Cambridge MD 21613   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Maryland Veterans Cem. 2/6  |  | 20c. LOCATION — City or Town, State<br>Hurlock Maryland   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>▶ Kenneth R. Thomas Jr.   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Thomas Funeral Home<br>700 Locust St. Cambridge MD 21613  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  | a. Anemic<br>DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |
|  |  | b. CVA<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |   |  |
|  |  | c. Multiple Myeloma<br>DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |
|  |  | d.   |  |   |  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>  |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                        |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Vinodrai Mehta M.D.   |  |  |  | 29c. LICENSE NUMBER<br>D15541   |  | 29d. DATE SIGNED (Month, Day, Year)<br>2/2/96   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Vinodrai Mehta M.D. 400 Aurora St. Cambridge, MD 21613  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>FEB 06 1996   |  | 32. REGISTRAR'S SIGNATURE<br>John A. [Signature]   |  |   |  |   |  |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04863

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Elsie Gray Woodland

2. Date of Death

Feb. 3, 1996

3. Time of Death

11 30 PM

4a. Facility Name (If not institution, give street and number)

Mallard Bay Nursing &amp; Rehab. Center

4b. City, Town, or Location of Death

Cambridge

4c. County of Death

Dorchester

Funeral  
Director

5. Social Security Number

218-20-6718

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

95

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Dec. 22, 1900 Maryland

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10a. State

MD.

10b. County

Dorchester

10c. City, Town or Location

Elliotts Island

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2320 Elliotts Island Rd.

10f. Zip Code

21869

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Canner

16b. Kind of Business/Industry

Cannery

17. Father's Name (First, Middle, Last)

Levin Spry Gray

18. Mother's Name (First, Middle, Maiden Surname)

Clara Moore Gray

19a. Informant's Name/Relationship (Type, Print) Son  
Granville R. Woodland19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  
319 Riverside Dr., Seaford, DE. 19973

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Elliotts UM Ch. Cem. 2-6

Data

20c. Location - City or Town, State

Elliott, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Curran-Bromwell Funeral Home, P.A.  
308 High St., Cambridge, MD., 21613

23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure

years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Organic Brain Syndrome

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Edmund J. MacLaughlin 4 Aurora St. Cambridge Md 21613

31. Date filed (Month, Day, Year)

FEB 08 1996

32. Registrar's Signature

John A. B. Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



96 04864

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |   |   |  |   |  |
|--|--|--|---|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>BETTY JUNE WALLER  |  |  |   | 2. DATE OF DEATH<br>MONTH 01 DAY 30 YEAR 96   |  | 3. TIME OF DEATH<br>6:30 p.m. M   |  |
| 4. SOCIAL SECURITY NUMBER<br>216-74-2387   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br>69 YRS. | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7. DATE OF BIRTH<br>(Month, Day, Year)<br>June 22 1926   |  | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland   |   |   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>601 Academy St.  |  |  |   | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Cambridge  |  | 9c. COUNTY OF DEATH<br>Dorchester   |  |
| RESIDENCE OF DECEDENT  |  |  |   |   |  |   |  |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Dorchester  |   | 10c. CITY, TOWN OR LOCATION<br>Cambridge  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>601 Academy St.  |  |  |   | 10f. ZIP CODE<br>21613  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |   | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: white                                  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8<br>College (1-4 or 5+) College   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>homemaker   |   | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>William H. Waller   |  |  |   | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Mary Nichols   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Mrs. Elsie W. Lentz  |  |  |   | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1023 Coronet Rd., Warminster PA. 18974   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Allen Cemetery 2/3/96   |   | 20c. LOCATION — City or Town, State<br>Allen Maryland   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Kenneth R. Thomas Jr.   |  |  |   | 22. NAME AND ADDRESS OF FACILITY<br>Thomas Funeral Home PA<br>700 Locust St. Cambridge MD 21613   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |   |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  | a. <i>Cardiac Arrhythmia (presumed)</i>  |   |   |  | Approximate Interval Between Onset and Death<br>1 day   |  |
|  |  | b. <i>Adult onset Diabetes mellitus</i>  |   |   |  | 5 yrs   |  |
|  |  | c. <i>HBP</i>  |   |   |  | 5 yrs   |  |
|  |  | d.   |   |   |  |   |  |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  |  |  |   |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Cerebral Palsy</i><br><i>Chronic Dehydrated State</i>   |  |  |   |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |   |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |   | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO              |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |   | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                      |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>  |  |  |   | 29c. LICENSE NUMBER<br>D26388   |  | 29d. DATE SIGNED (Month, Day, Year)<br>1-31-96  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>Michael Fadden 302 Collins Harlock md 21693</i>  |  |  |   |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>FEB 06 1996   |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |   |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR  |  |   |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 96 04865  |  |   |  |
|--|--|---|--|---|--|--|--|---|--|---|--|
| CERTIFICATE OF DEATH   |  |   |  | REG. NO.  |  |  |  |   |  |   |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Elvin Milton Wise  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>Feb. 7, 1996  |  |  |  | 3. TIME OF DEATH<br>3:15 P. M.  |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br>217-28-6760   |  | 5. SEX<br>XX M 2 F  |  | 6. AGE (In yrs. last birthday)<br>68 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>Jan. 13, 1928 |  | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Homewood Nursing Care Center   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Williamsport   |  |  |  | 9c. COUNTY OF DEATH<br>Washington   |  |   |  |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Washington   |  | 10c. CITY, TOWN OR LOCATION<br>Hagerstown   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 YES 2 NO  |  |   |  |
| 10e. STREET AND NUMBER<br>203 Landis Road  |  |   |  | 10f. ZIP CODE<br>21740  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |   |  |
| 11. MARITAL STATUS<br>1 Never Married 2 Married<br>3 Widowed 4 Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 YES 2 NO Specify:  |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                            |  |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Maintenance                 |  | 16b. KIND OF BUSINESS/INDUSTRY<br>School Board  |  |  |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Roy M. Wise   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Estella I. Jones   |  |  |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Kathy L. Rohrer  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>12025 Steven Ave. Smithsburg, MD 21783 |  |  |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 Burial 2 Cremation 3 Removal from State<br>4 Donation 5 Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Beaver Creek Cemetery 2/9/96                           |  | 20c. LOCATION — City or Town, State<br>Hagerstown, Maryland   |  |  |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>M. M. Jones   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>Davis Funeral Home 12525 Bradbury Ave. Smithsburg, MD 21783   |  |  |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. SEPTIC SHOCK<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. NEUTROPENIA<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. CHRONIC LYMPHOBLASTIC LEUKEMIA<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. AND CHEMOTHERAPY<br>Sequitely flat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |   |  |   |  |  |  | Approximate Interval Between Onset and Death<br>1-2 Days<br>Several days<br>Years<br>Months |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 YES 2 NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 YES 2 NO |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN  |  |   |  |   |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 YES 2 NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA<br>OTHER: 4 Nursing Home 5 Residence 6 Other (Specify) |  |   |  |  |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 Natural 2 Accident 3 Suicide 4 Homicide<br>5 Pending Investigation 6 Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 YES 2 NO                   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Medical Director   |  |   |  | 29c. LICENSE NUMBER<br>D17067                        |  | 29d. DATE SIGNED (Month, Day, Year)<br>2/8/96   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>STEVEN M. JONES 747 RANDOLPH AVE THEODORUS, MD  |  |   |  |   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>FEB 9 1996  |  |   |  | 32. REGISTRAR'S SIGNATURE<br>John H. H. H.  |  |  |  |   |  |   |  |

2000 21



Amended #10b &amp; 10e, 2/9/96, LMG, Talbot

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04866

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Lucy Anna White</i>  |  |  |  | 2. DATE OF DEATH<br>MONTH <i>February</i> DAY <i>6</i> YEAR <i>1996</i>   |  | 3. TIME OF DEATH<br><i>5:45 PM</i>  |  |
| 4. SOCIAL SECURITY NUMBER<br><i>215-26-4433</i>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><i>64 YRS.</i>  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>April 27, 1931</i>                                 |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>PENINSULA REGIONAL MEDICAL CENTER</i>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>SALISBURY</i>   |  | 9c. COUNTY OF DEATH<br><i>WICOMICO</i>  |  |
| 10a. STATE<br><i>Maryland</i>   |  | 10b. COUNTY<br><i>Wicomico Somerset</i>  |  | 10c. CITY, TOWN OR LOCATION<br><i>Princess Anne</i>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><i>11456 Bratten Ave.</i>   |  |  |  | 10f. ZIP CODE<br><i>21853</i>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>Black</i>                         |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>7th</i> College (14 or 5+) <i>Seafood</i>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>Seafood</i>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>Industry</i>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Elmer Purnell</i>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Sadie White</i>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Henry White</i>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>P.O. Box 391, Princess Anne, Md. 21853</i>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>St. James U.M. Church Cemetery</i>   |  | 20c. LOCATION — City or Town, State<br><i>2/12/96 Princess Anne, Md.</i>  |  | 20d. DATE   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>John A. Prince</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>Bennie Smith Funeral Home<br/>426 Dover Street, Easton, Maryland 21601</i>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Intracerebral hemorrhage</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><i>Hypertension</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><i>diabetes mellitus</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>   |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br><i>M</i>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>John H. Bellis M.D.</i>  |  | 29c. LICENSE NUMBER<br><i>D28137</i>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>2/9/96</i>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>EDWIN H. BELLIS M.D. 560 RIVERSIDE DR. SALISBURY, MD. 21801</i>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><i>FEB 09 1996</i>   |  | 32. REGISTRAR'S SIGNATURE<br><i>John Andrew Randall</i>  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04867

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ROBERT FRANKLIN WEEMS

2. Date of Death

Month  
JanDay  
31Year  
96

3. Time of Death

11:25pm

4a. Facility Name (If not institution, give street and number)

Memorial Hospital at Easton

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

Funeral  
Director

5. Social Security Number

214-28-3613 X

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

68

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 23, 1927

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Talbot

10c. City, Town or Location

Royal Oak

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

25698 Edgeview Road

10f. Zip Code

21662

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No -  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

11

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Partner - Construction Co.

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Edmund L. Weems

18. Mother's Name (First, Middle, Maiden Surname)

Ida Stiertz

19a. Informant's Name/Relationship (Type, Print)

Charlotte H. Weems - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P. O. Box 101, Royal Oak, MD. 21662

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Capitol Crematory

Feb. 1, 1996

Dover, Delaware

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Harrison E. Leonard

22. Name and Address of Facility

Harrison E. Leonard Funeral Home

312 S. Talbot St., St. Michaels, MD.

21663

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

YEARS

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

YEARS

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CARDIOMYOPATHY

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☐ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient ☒ ER/Outpatient ☐ DOA

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending  
Investigation  
☐ Accident ☐ Could not be  
determined  
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?☐ Yes ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

W. S. Bremer

29c. License number

D26350

29d. Date signed (Month, Day, Year)

2/1/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WILLIAM S. BREMER MD

ST. MICHAELS MD 21663

31. Date filed (Month, Day, Year)

FEB 06 1996

32. Registrar's Signature

John Davidson Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR   |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 96 04868   |                                     |                                   |  |
|---|--|--|--|---|--|---|--|--|-------------------------------------|-----------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)  |  |  |  | 2. DATE OF DEATH  |  |   |  | 3. TIME OF DEATH   |                                     |                                   |  |
| Virginia Swartz Walsh   |  |  |  | February 8, 1996  |  |   |  | 1013 M   |                                     |                                   |  |
| 4. SOCIAL SECURITY NUMBER   |  | 5. SEX   |  | 6. AGE (In yrs. last birthday)  |  | 7. DATE OF BIRTH  |  | 8. BIRTHPLACE (State or Foreign Country)                                     |                                     |                                   |  |
| 301-10-0646   |  | 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                 |  | 78 YRS.   |  | Oct. 16, 1917   |  | West Virginia  |                                     |                                   |  |
| 9a. FACILITY NAME (If not Institution, give street and number)  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH   |  |   |  | 9c. COUNTY OF DEATH  |                                     |                                   |  |
| Medpointe   |  |  |  | Elkton  |  |   |  | Cecil  |                                     |                                   |  |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |   |  |  |                                     |                                   |  |
| 10a. STATE  |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION   |  |   |  | 10d. INSIDE CITY LIMITS?   |                                     |                                   |  |
| Maryland  |  | Cecil  |  | Elkton  |  |   |  | 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO      |                                     |                                   |  |
| 10e. STREET AND NUMBER  |  |  |  | 10f. ZIP CODE   |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?  |                                     |                                   |  |
| 110 Newark Avenue   |  |  |  | 21921   |  |   |  | U.S.A.   |                                     |                                   |  |
| 11. MARITAL STATUS  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN?  |  | 14. RACE — American Indian, Black, White, etc.  |  |  |                                     |                                   |  |
| 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>Specify:   |  | Specify: White  |  |  |                                     |                                   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)  |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY   |                                     |                                   |  |
| Elementary/Secondary (0-12) 2   |  |  |  | College (1-4 or 5+) 2   |  |   |  | Cost Accountant  |                                     |                                   |  |
|   |  |  |  |   |  |   |  | Aberdeen Proving Ground  |                                     |                                   |  |
| 17. FATHER'S NAME (First, Middle, Last)   |  |  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)   |  |  |                                     |                                   |  |
| Charles Swartz  |  |  |  |   |  | Elizabeth Conley  |  |  |                                     |                                   |  |
| 19a. INFORMANT'S NAME (Type/Print)  |  |  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |  |  |                                     |                                   |  |
| Karen W. Clark  |  |  |  |   |  | 3705 Mt. Airey Lane - Annandale, VA 22003   |  |  |                                     |                                   |  |
| 20a. METHOD OF DISPOSITION  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)   |  |   |  | 20c. LOCATION — City or Town, State  |                                     |                                   |  |
| 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | Elkton Cemetery   |  |   |  | 2-9-1996 Elkton, Maryland  |                                     |                                   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE   |  |  |  |   |  | 22. NAME AND ADDRESS OF FACILITY  |  |  |                                     |                                   |  |
|   |  |  |  |   |  | Hicks Home for Funerals, P.A.<br>103 W. Stockton St., Elkton, MD 21921-5521                   |  |  |                                     |                                   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |  |  |   |  |   |  |  |                                     |                                   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Pneumonia</u>   |  |  |  |   |  |   |  |  |                                     |                                   |  |
| b. DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |   |  |  |                                     |                                   |  |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  |  |  |   |  |   |  |  |                                     |                                   |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |   |  |  |                                     |                                   |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |   |  |  |                                     |                                   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |   |  |  |                                     |                                   |  |
| <u>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</u>  |  |  |  |   |  |   |  |  |                                     |                                   |  |
| <u>COR PULMONALE</u>  |  |  |  |   |  |   |  |  |                                     |                                   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  |   |  |   |  |  |                                     |                                   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?  |  |  |  | 26. PLACE OF DEATH (Check only one)   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?   |                                     |                                   |  |
| 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO      |                                     |                                   |  |
| 27. MANNER OF DEATH   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY   |  | 28c. INJURY AT WORK?   |                                     | 28d. DESCRIBE HOW INJURY OCCURRED |  |
| 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide |  |  |  |   |  | M   |  | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                 |                                     |                                   |  |
|   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |                                     |                                   |  |
| 29a. CERTIFIER (Check only one)   |  |  |  |   |  |   |  |  |                                     |                                   |  |
| 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |  |                                     |                                   |  |
| 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |  |                                     |                                   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER   |  |  |  |   |  | 29c. LICENSE NUMBER   |  |  | 29d. DATE SIGNED (Month, Day, Year) |                                   |  |
| Morte Makous, MD  |  |  |  |   |  | D-44783   |  |  | 2-9-96                              |                                   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)   |  |  |  |   |  |   |  |  |                                     |                                   |  |
| 111 W. HIGH ST., ELKTON, MD 21921   |  |  |  |   |  |   |  |  |                                     |                                   |  |
| 31. DATE FILED (Month, Day, Year)   |  |  |  | 32. REGISTRAR'S SIGNATURE   |  |   |  |  |                                     |                                   |  |
| FEB 13 1996   |  |  |  |    |  |   |  |  |                                     |                                   |  |



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR  |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 96 04869  |  |   |  |                                   |  |
|---|--|--|--|--|--|--|--|---|--|---|--|-----------------------------------|--|
| CERTIFICATE OF DEATH  |  |  |  | REG. NO.   |  |  |  |   |  |   |  |                                   |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Helen A. Wisnewski</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>February 9, 1996</b>  |  |  |  | 3. TIME OF DEATH<br><b>6:40 A M</b>   |  |   |  |                                   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>124-22-1098</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>65</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>April 7, 1930</b>                |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>New York</b>   |  |   |  |                                   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>38 Hollis Circle</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Elkton</b>   |  |  |  | 9c. COUNTY OF DEATH<br><b>Cecil</b>   |  |   |  |                                   |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Cecil</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Elkton</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO       |  |   |  |                                   |  |
| 10e. STREET AND NUMBER<br><b>38 Hollis Circle</b>   |  |  |  | 10f. ZIP CODE<br><b>21921</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  |                                   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b> |  |   |  |   |  |                                   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (9-12)</b><br><b>12</b>   |  | 15a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>  |  | 15b. KIND OF BUSINESS/INDUSTRY<br><b>n/a</b>   |  |  |  |   |  |   |  |                                   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Joseph Affeldt</b>  |  |  |  | 16. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Dorothy (unknown)</b>  |  |  |  |   |  |   |  |                                   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>John J. Wisnewski</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>38 Hollis Circle - Elkton, MD 21921</b>  |  |  |  |   |  |   |  |                                   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATED OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>R.A. Ferris &amp; Company</b><br><b>2-9 1996</b>  |  | 20c. LOCATION — City or Town, State<br><b>West Chester, PA</b>   |  |  |  |   |  |   |  |                                   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Donald S. Hicks</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Hicks Home for Funerals, P.A.</b><br><b>103 W. Stockton St., Elkton, MD 21921-5521</b>  |  |  |  |   |  |   |  |                                   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Adenocarcinoma of the Lung</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> |  |  |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |                                   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>February 9, 1996</b>          |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>H. Farkas, MD</b>  |  | 29c. LICENSE NUMBER<br><b>D15314</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>February 9, 1996</b>             |  |   |  |   |  |                                   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>H. Farkas, MD Northern Chesapeake Hospice, 239 S. Bridge St., Elkton, MD 21921</b>  |  |  |  |  |  |  |  |   |  |   |  |                                   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 13 1996</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Stewman-Randall</b>  |  |  |  |   |  |   |  |                                   |  |

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04870

|   |  |   |  |   |   |   |   |   |  |   |  |
|---|--|---|--|---|---|---|---|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Robert RICHARD Wescoe</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>February 5, 1996</b>   |   | 3. TIME OF DEATH<br><b>6:44 A M</b>   |   |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>302-44-4155</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>48</b> YRS.  |   | 7. DATE OF BIRTH (Month, Day, Year)<br><b>MARCH 18, 1947</b>                                |   | 8. BIRTHPLACE (State or Foreign Country)<br><b>PENNSYLVANIA</b>                                       |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>SOUTHERN MARYLAND HOSPITAL</b>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>CLINTON</b>   |   |   | 9c. COUNTY OF DEATH<br><b>PRINCE GEORGE</b>   |   |  |   |  |
| 10a. STATE<br><b>MARYLAND</b>   |  | 10b. COUNTY<br><b>CHARLES</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>WALDORF</b>   |   |   | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   |  |   |  |
| 10e. STREET AND NUMBER<br><b>3588 PALMETTO COURT</b>  |  |   |  | 10f. ZIP CODE<br><b>20602</b>   |   | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |   |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |   |   | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>                      |   |  |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>12</b>   |  | 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>ELECTRONIC TECHNICIAN</b>  |  |   | 16b. KIND OF BUSINESS/INDUSTRY<br><b>FEDERAL GOVERNMENT</b> |   |   |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>FREDERICK H. WESCOE</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>MALVA THARPE</b>  |   |   |   |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>CONSUELO J. WISCOE</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2588 PALMETTO COURT WALDORF, MARYLAND 20602</b>   |   |   |   |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>HUNT CREAMATORY</b>   |  | DATE<br><b>2/09</b>   |   | 20c. LOCATION — City or Town, State<br><b>WALDORF, MARYLAND</b>                             |   |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE EXCHANGER<br><b>BENJAMIN M. MATTHEWS M-00658</b>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>THE HUNTT FUNERAL HOME, INC.<br/>P.O. BOX 156 WALDORF, MARYLAND</b>  |   |   |   |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cerebral hemorrhage</b><br><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. <b>hypertension</b><br>b. <b>hypertension</b><br>c. <b>hypertension</b><br>d. <b>hypertension</b> |  |   |  |   |   |   |   | Approximate interval Between Onset and Death  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>   |  |   |  |   |   |   |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |   |   |   |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |   | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |   |   |   |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |   |   |   |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Augusta P. Rodriguez MS</b>   |  |   |  | 29c. LICENSE NUMBER<br><b>D21230</b>  |   | 29d. DATE SIGNED (Month, Day, Year)<br><b>February 5, 1996</b>                              |   |   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Augusta P. Rodriguez 2 AMP 5009 Rayburn Ct. Cp. 890 MD 20748</b>  |  |   |  |   |   |   |   |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 09 1996</b>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><b>John Davidson Randall</b>   |   |   |   |   |  |   |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 96 04871

|   |   |  |   |   |  |  |  |  |   |    |                         |  |    |          |    |        |    |
|---|---|--|---|---|--|--|--|--|---|----|-------------------------|--|----|----------|----|--------|----|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Marvin Wilford Wenk   |  |   |   | 2. Date of Death<br>Month Day Year<br>February 1, 1996   |  | 3. Time of Death<br>9:03 A M                                     |  |   |    |                         |  |    |          |    |        |    |
|   | 4a. Facility Name (If not institution, give street and number)<br>Physicians Memorial Hospital  |  |   |   | 4b. City, Town, or Location of Death<br>La Plata   |  | 4c. County of Death<br>Charles                                   |  |   |    |                         |  |    |          |    |        |    |
| Funeral<br>Director   | 5. Social Security Number<br>217-32-2078  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>79 Yrs.   | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>Aug. 19, 1916   |  | 9. Birthplace (State or Foreign Country)<br>Maryland |   |    |                         |  |    |          |    |        |    |
|   | Usual Residence of Decedent   |  |   |   |  |  |  |  |   |    |                         |  |    |          |    |        |    |
| To Be Completed by<br>Funeral Director  | 10a. State<br>Md.   | 10b. County<br>Charles   | 10c. City, Town or Location<br>Port Tobacco   |   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   |    |                         |  |    |          |    |        |    |
|   | 10e. Street and Number<br>8005 Port Tobacco Road  |  |   | 10f. Zip Code<br>20677  |  | 10g. Citizen of What Country?<br>U.S.A.  |  |  |   |    |                         |  |    |          |    |        |    |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |   |    |                         |  |    |          |    |        |    |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 3<br>College (1-4or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use, retired)<br>Heavy Equipment Operator                |   |  | 16b. Kind of Business/Industry<br>State Highway Administration   |  |  |   |    |                         |  |    |          |    |        |    |
|   | 17. Father's Name (First, Middle, Last)<br>Ernest Wenk  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Gertrude Garner   |  |  |  |   |    |                         |  |    |          |    |        |    |
| To Be Completed by<br>Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br>Beverly S. Wenk, Daughter   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>8005 Port Tobacco Rd., Port Tobacco, Md. 20677  |  |  |  |   |    |                         |  |    |          |    |        |    |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Mt. Rest Cemetery   |   | Date<br>2/10/96  | 20c. Location - City or Town, State<br>La Plata, Maryland  |  |  |   |    |                         |  |    |          |    |        |    |
|   | 21. Signature of Funeral Service Licensee<br><i>Dayton C Echols</i>   |  |   |   | 22. Name and Address of Facility<br>AREHART-ECHOLS FUNERAL HOME, INC.<br>P. O. Box 567, La Plata, Md. 20646  |  |  |  |   |    |                         |  |    |          |    |        |    |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |   |  |  |  |  |   |    |                         |  |    |          |    |        |    |
|   | <table border="0"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td>Electrolyte Abnormality</td> <td rowspan="4">Approximate Interval Between Onset and Death</td> </tr> <tr> <td>b.</td> <td>AZOTEMIA</td> </tr> <tr> <td>c.</td> <td>SEPSIS</td> </tr> <tr> <td>d.</td> <td></td> </tr> </table> |  |   |   |  |  |  |  | Immediate Cause (Final disease or condition resulting in death) | a. | Electrolyte Abnormality | Approximate Interval Between Onset and Death | b. | AZOTEMIA | c. | SEPSIS | d. |
| Immediate Cause (Final disease or condition resulting in death)   | a.  | Electrolyte Abnormality  | Approximate Interval Between Onset and Death  |   |  |  |  |  |   |    |                         |  |    |          |    |        |    |
|   | b.  | AZOTEMIA   |   |   |  |  |  |  |   |    |                         |  |    |          |    |        |    |
|   | c.  | SEPSIS   |   |   |  |  |  |  |   |    |                         |  |    |          |    |        |    |
|   | d.  |  |   |   |  |  |  |  |   |    |                         |  |    |          |    |        |    |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |  |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |  |   |    |                         |  |    |          |    |        |    |
|   |   |  |   |   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |   |    |                         |  |    |          |    |        |    |
|   |   |  |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |   |    |                         |  |    |          |    |        |    |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |   |    |                         |  |    |          |    |        |    |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accidental 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |   | 28a. Date of Injury (Month, Day, Year)                                     |   | 28b. Time of Injury<br>M  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred                                |  |   |    |                         |  |    |          |    |        |    |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |   | 29b. Signature and title of certifier<br><i>John Davidson Randall</i> Attending   |  | 29c. License number<br>D-44436   |  | 29d. Date signed (Month, Day, Year)<br>Feb 01-96     |   |    |                         |  |    |          |    |        |    |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>Ashvinkumar Patel, M.D. 603 Post Office Road Suite 207 Waldorf, Maryland 20602  |   |  |   |   |  |  |  |  |   |    |                         |  |    |          |    |        |    |
| 31. Date filed (Month, Day, Year)<br>FEB 12 1996  |   |  |   | 32. Registrar's Signature<br><i>John Davidson Randall</i>   |  |  |  |  |   |    |                         |  |    |          |    |        |    |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04872

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

WALTER SMITH WARREN

2. Date of Death

Month Day Year  
FEBRUARY 02 1996

3. Time of Death

12:55 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

112 LIBERTY WAY

4b. City, Town, or Location of Death

FRUITLAND

4c. County of Death

WICOMICO

5. Social Security Number

219-03-0990

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
September 30, 1920

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Wicomico

10c. City, Town or Location

Fruitland

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

112 Liberty Way

10f. Zip Code

21826

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☐ No

If Yes, Give Year or Dates: Marines

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12College (13-16)  
0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Security Guard

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

Harry J. Warren

18. Mother's Name (First, Middle, Maiden Surname)

Minnie Powell

19a. Informant's Name/Relationship (Type, Print)

Thelma L. Warren

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

112 Liberty Way, Fruitland, MD 21826

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Springhill Memory Gardens

Date

2/6/96

20c. Location - City or Town, State

Hebron, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Holloway Funeral Home

501 Snow Hill Rd., Salisbury, MD 21801

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

a. INTRACRANIAL SUBARACHNOID HEMORRHAGE

Due to (or as a consequence of):

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

HOTO ONLY

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☒ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

2 1 96

28b. Time of Injury

2:55 P M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

SUBJECT'S HOT SELF

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

HOME

28f. Location (Street and Number or Rural Route Number, City or Town, State)

112 LIBERTY WAY WICOMICO CO. MD

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

FEBRUARY 02, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Margarita Korell M.D. 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

FEB 05 1996

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 96 04873

Physician  
/Medical  
ExaminerFuneral  
Director

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Lois Fuller Willis</b>  |  |   |  | 2. Date of Death<br>Month Day Year<br><b>Jan 1 1996</b>  |  | 3. Time of Death<br><b>2:00 a.m.</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Memorial Hospital at Easton, Inc.</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Easton</b>  |  | 4c. County of Death<br><b>Talbot</b>   |  |
| 5. Social Security Number<br><b>051-22-5224</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>69</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Dec 23, 1926</b>                           |  |
| 9. Birthplace (State or Foreign Country)<br><b>New York</b>  |  | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Queen Anne's</b>   |  | 10c. City, Town or Location<br><b>Stevensville</b>                                   |  |
| 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>113 State Street</b>   |  | 10f. Zip Code<br><b>21666</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                       |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>              |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>College</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Housewife</b>                         |  | 16b. Kind of Business/Industry   |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>John Sherman Fuller</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Julinne Spinnewyn</b>  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Roger Lawrence Willis</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>113 State St., Stevensville, MD 21666</b>  |  |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory</b>  |  | Date<br><b>Jan 2, 1996</b>   |  | 20c. Location - City or Town, State<br><b>Baltimore, MD</b>                          |  |
| 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>Tom Helfenbein Funeral Homes, P.A.<br/>106 Shamrock Rd., Chester, MD 21619</b>  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>Early gangrene right leg</b><br>Due to (or as a consequence of):<br><br>b. <b>Peripheral Arterial Insufficiency</b><br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of):<br><br>Approximate interval Between Onset and Death<br><br>1 D<br><br>Many Yrs |  |   |  |  |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |   |  |  |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |  |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |  |  |  |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |   |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of injury (Month, Day Year)   |  | 28b. Time of injury<br><b>M</b>  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |  |  |  |  |
| 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>D01225</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>2-13-96</b>  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)   |  |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>1/3/96</b>   |  | 32. Registrar's Signature<br>   |  |  |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04874

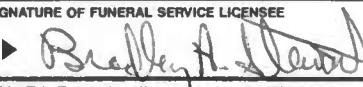


|   |  |  |  |   |  |  |   |   |  |   |  |   |  |
|---|--|--|--|---|--|--|---|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>John William Warfield, Jr.  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>February 3, 1996  |  | 3. TIME OF DEATH<br>5:00 P M   |   |   |  |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br>217-46-4662  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>49 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>Sept. 3, 1946                              |   | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |  |   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Garrett County Memorial Hospital  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Oakland  |  |  | 9c. COUNTY OF DEATH<br>Garrett  |   |  |   |  |   |  |
| 10a. STATE<br>MD  |  | 10b. COUNTY<br>Garrett   |  | 10c. CITY, TOWN OR LOCATION<br>Oakland  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |  |   |  |   |  |
| 10e. STREET AND NUMBER<br>116 Crook Crest   |  |  |  | 10f. ZIP CODE<br>21550  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |   |   |  |   |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                                 |   |  |   |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>4  |  | 15a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Soil Engineer   |  |   | 15b. KIND OF BUSINESS/INDUSTRY<br>Soil Engineering |  |   |   |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>John William Warfield, Jr.   |  |  |  | 16. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Dorothy Elnora Cavey   |  |  |   |   |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Jeeraporn Warfield  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>116 Crook Crest, Oakland, Maryland 21550   |  |  |   |   |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Omega Crematory   |  | DATE<br>2/8   |  | 20c. LOCATION — City or Town, State<br>Morgantown, WV                                |   |   |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Breda, A. Stuebel  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Stewart Funeral Home<br>32 S. Second St., Oakland, MD 21550   |  |  |   |   |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Idiopathic Cardiomyopathy<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |  |   | Approximate Interval Between Onset and Death<br>Months  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |   |  |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |   |   |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |   |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |   |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |   | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>X Karl Schwalm, MD   |  | 29c. LICENSE NUMBER<br>D27205   |  | 29d. DATE SIGNED (Month, Day, Year)<br>2/5/96 |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Dr. Karl Schwalm, MD 311 N. Fourth St., Oakland, Maryland 21550  |  |  |  |   |  |  |   |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>FEB - 6 1996   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>John William Warfield  |  |  |   |   |  |   |  |   |  |

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Charles Albert WENDLANDT   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>February 14, 1996   |  | 3. TIME OF DEATH<br>M  |  |
| 4. SOCIAL SECURITY NUMBER<br>143-20-5349   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>93 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>July 1, 1902   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>New Jersey   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>Dennett Road Manor Nursing Home   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Oakland   |  |
| 9c. COUNTY OF DEATH<br>Garrett   |  |  |  | 10a. STATE<br>MD  |  | 10b. COUNTY<br>Garrett   |  |
| 10c. CITY, TOWN OR LOCATION<br>Oakland   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br>1118 Dennett Road  |  |
| 10f. ZIP CODE<br>21550   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>WW I  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  |  |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White  |  |  |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8th<br>College (1-4 or 5+) College (1-4 or 5+)  |  |  |  |
| 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Policeman   |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Law Enforcement   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Albert ----- Wendlandt  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Anna ----- Schmidt   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Georgia Tiarno   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3780 Cazador St., Los Angeles, CA 90065  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Omega Crematory  |  |  |  |
| 20c. LOCATION — City or Town, State<br>2/17 Morgantown, WV   |  |  |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |  |
| 22. NAME AND ADDRESS OF FACILITY<br>Stewart Funeral Home<br>32 S. Second St., Oakland, MD 21550  |  |  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. lung cancer<br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>atherosclerotic cardiovascular disease<br>tobacco use did contribute to the cause of death   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |  |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  |  |  |
| 28a. DATE OF INJURY (Month, Day, Year)   |  |  |  | 28b. TIME OF INJURY<br>M  |  |  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br> M.D.  |  |  |  | 29c. LICENSE NUMBER<br>D25759   |  | 29d. DATE SIGNED (Month, Day, Year)<br>Feb. 14, 1996   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Walter K. Naumann, M.D., PO Box 247, Accident MD 21520  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>FEB 16 1996   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 29 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR   |  |   |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |                                |  |  | 96 04876  |  |  |  |   |  |                                      |  |   |  |
|---|--|---|--|--|--------------------------------|--|--|---|--|--|--|---|--|--------------------------------------|--|---|--|
| CERTIFICATE OF DEATH  |  |   |  | REG. NO.   |                                |  |  |   |  |  |  |   |  |                                      |  |   |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>STANLEY WILCOX</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH <b>1</b> DAY <b>30</b> YEAR <b>96</b>  |                                |  |  | 3. TIME OF DEATH<br><b>2135</b> M                     |  |  |  |   |  |                                      |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>266-28-2696</b>   |  | 5. SEX<br><b>1</b> M <b>2</b> F   | 6. AGE (In yrs. last birthday)<br><b>80</b> YRS. | IF UNDER 1 YEAR<br>MONTHS DAYS   | IF UNDER 24 HRS.<br>HOURS MIN. | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>7/19/15</b>                     |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>NY</b> |  |  |  |   |  |                                      |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Atlantic General Hospital</b>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Berlin</b>   |                                |  |  | 9c. COUNTY OF DEATH<br><b>Worcester</b>               |  |  |  |   |  |                                      |  |   |  |
| 10a. STATE<br><b>MD</b>   |  | 10b. COUNTY<br><b>Worcester</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Berlin</b>   |                                |  |  | 10d. INSIDE CITY LIMITS?<br><b>1</b> YES <b>2</b> NO  |  |  |  |   |  |                                      |  |   |  |
| 10e. STREET AND NUMBER<br><b>29 Anchor Way Dr.</b>  |  |   |  | 10f. ZIP CODE<br><b>21811</b>  |                                | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                  |  |   |  |  |  |   |  |                                      |  |   |  |
| 11. MARITAL STATUS<br><b>1</b> Never Married <b>2</b> Married<br><b>3</b> Widowed <b>4</b> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><b>1</b> YES <b>2</b> NO<br>IF YES, GIVE WAR OR DATES<br><b>WW II</b>  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> YES <b>2</b> NO Specify: |                                | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>white</b>      |  |   |  |  |  |   |  |                                      |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>2</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Maintenance Worker</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Private Hospital</b>  |                                |  |  |   |  |  |  |   |  |                                      |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Guy Wilcox</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Nora Crouch</b>  |                                |  |  |   |  |  |  |   |  |                                      |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Margaret Offutt</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>33 Anchor Way Dr. Berlin, MD 21811</b>           |                                |  |  |   |  |  |  |   |  |                                      |  |   |  |
| 20a. METHOD OF DISPOSITION<br><b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State<br><b>4</b> Donation <b>5</b> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Cape Henlopen Crematory 1/31/96</b>   |  | DATE<br><b>1/31/96</b>   |                                | 20c. LOCATION — City or Town, State<br><b>Frankford, DE</b>                  |  |   |  |  |  |   |  |                                      |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Burbage Funeral Home<br/>108 Williams St. Berlin, MD 21811</b>  |                                |  |  |   |  |  |  |   |  |                                      |  |   |  |
| 23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. MYOCARDIAL INFARCTUM</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. CORONARY ARTERY DISEASE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c. STROKE FIBRILLATION</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d.</b><br>Approximate Interval Between Onset and Death<br><b>IMMEDIATE</b> |  |   |  |  |                                |  |  |   |  |  |  |   |  |                                      |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |                                |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><b>1</b> YES <b>2</b> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1</b> YES <b>2</b> NO |  |                                      |  |   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |   |  |  |                                |  |  |   |  |  |  |   |  |                                      |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1</b> YES <b>2</b> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA<br>OTHER: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify) |  |  |                                |  |  |   |  |  |  |   |  |                                      |  |   |  |
| 27. MANNER OF DEATH<br><b>1</b> Natural <b>5</b> Pending Investigation<br><b>2</b> Accident <b>6</b> Could not be determined<br><b>3</b> Suicide <b>4</b> Homicide  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M   |                                | 28c. INJURY AT WORK?<br><b>1</b> YES <b>2</b> NO                             |  | 28d. DESCRIBE HOW INJURY OCCURRED                     |  |  |  |   |  |                                      |  |   |  |
|   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |                                | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |  |   |  |  |  |   |  |                                      |  |   |  |
| 29a. CERTIFIER (Check only one)<br><b>1</b> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  |                                |  |  |   |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>   |  | 29c. LICENSE NUMBER<br><b>046257</b> |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>1/30/96</b> |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)<br><b>344 Franklin Ave. Suite 103 Berlin, MD 21811</b>   |  |   |  |  |                                |  |  |   |  |  |  |   |  |                                      |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>JAN 31 1996</b>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |                                |  |  |   |  |  |  |   |  |                                      |  |   |  |

00 64838

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR   |  |  |   | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 96 04877  |  |   |  |
|--|--|--|---|---|--|--|--|---|--|---|--|
| CERTIFICATE OF DEATH   |  |  |   | REG. NO.  |  |  |  |   |  |   |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Carsten B. Wehrenberg  |  |  |   | 2. DATE OF DEATH<br>Feb 4 DAY 1996 YEAR   |  |  |  | 3. TIME OF DEATH<br>7:00 a.m.   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br>218-01-8409   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br>86 YRS. | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>Aug 5 1909  |  | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland                                 |  |   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Bloom Valley Senior Care   |  |  |   | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Westminster  |  |  |  | 9c. COUNTY OF DEATH<br>Carroll  |  |   |  |
| 10a. STATE<br>Md   |  |  |   | 10b. COUNTY<br>Carroll  |  | 10c. CITY, TOWN OR LOCATION<br>Sykesville  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO       |  |   |  |
| 10e. STREET AND NUMBER<br>1300 Judges Court  |  |  |   | 10f. ZIP CODE<br>21784  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>United States                                       |  |   |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |   | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                     |  |   |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Tool Engineer   |   | 16b. KIND OF BUSINESS/INDUSTRY<br>Glenn L. Martin, Co.  |  |  |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Frederick Wehrenberg  |  |  |   | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Florence Kent  |  |  |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Mr. Russell Wantz (nephew)   |  |  |   | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>Loring Byers Funeral Directors<br>8728 Liberty Road Randallstown, Md 21133                         |  |  |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Bruid Ridge Cemetery 2/26/96  |   | DATE<br>2/26/96   |  | 20c. LOCATION — City or Town, State<br>Pikesville, Md.                               |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Joseph J. Kellner</i>  |  |  |   | 22. NAME AND ADDRESS OF FACILITY<br>Loring Byers Funeral Directors, Inc.<br>8728 Liberty Road Randallstown, Md 21133  |  |  |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>ARRHYTHMIA</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <u>PULMONARY FAILURE</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <u>METASTATIC PROSTATE CANCER</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. <u>PROSTATE CA</u> |  |  |   |   |  |  |  | Approximate interval Between Onset and Death<br>MINS.<br>MINS.<br>MOS.<br>YR.                             |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |   |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>  |  |  |   |   |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |  |  |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Other (Specify)   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |   | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
|  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |   |   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                              |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |   |   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Phieps N. Phieps M.D., Deputy ME.</i>  |  |  |   |   |  | 29c. LICENSE NUMBER<br>D36908  |  | 29d. DATE SIGNED (Month, Day, Year)<br>2/7/96   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>11722 REISTERSTOWN RD. REISTERSTOWN MD. 21136   |  |  |   |   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>FEB - 7 1996  |  |  |   | 32. REGISTRAR'S SIGNATURE<br><i>John A. Randall</i>   |  |  |  |   |  |   |  |

728



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

96 04878

REG. NO.

|   |  |  |  |   |  |   |   |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Jessie Mary WARNER  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>January 27, 1996  |  | 3. TIME OF DEATH<br>5:30 A. M   |   |
| 4. SOCIAL SECURITY NUMBER<br>213-74-0599  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 8. AGE (In yrs. last birthday)<br>89 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>June 15, 1906  |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Montevue Home   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Frederick  |  | 9c. COUNTY OF DEATH<br>Frederick  |   |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |   |   |
| 10a. STATE<br>Maryland  |  | 10b. COUNTY<br>Frederick   |  | 10c. CITY, TOWN OR LOCATION<br>Frederick  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br>355 Montevue Lane   |  |  |  | 10f. ZIP CODE<br>21702  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                                    |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8<br>College (1-4 or 5+) _____   |  | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Homemaker  |  | 15b. KIND OF BUSINESS/INDUSTRY<br>Own Home  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>James HOOD   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Mary Catherine WALKER  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>Mr. Wallace E. Warner   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>6009 Keyser Lane, Frederick, MD 21702  |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Green Mount Cemetery, Jan. 31, 1996   |  | 20c. LOCATION — City or Town, State<br>Baltimore, Maryland  |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>▶ Allan H. Ruby MO0703   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Keeney & Basford P.A. Funeral Home<br>106 East Church St., Frederick, MD 21701  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Atherosclerotic Heart Disease</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. _____<br>c. _____<br>d. _____<br>DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  |   | Approximate interval between Onset and Death<br>yrs   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Diabetes Mellitus, Hypertension</u>  |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |   |  |   |   |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  |   |  |   |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide<br>3 <input type="checkbox"/> Sudden 7 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |   |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |   |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |   |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Casper E. Cline, III, M.D.   |  |  |  | 29c. LICENSE NUMBER<br>D16428   |  | 29d. DATE SIGNED (Month, Day, Year)<br>1/29/96  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Dr. Casper E. Cline, III, M.D., 300 West Ninth Street, Frederick, MD 21701   |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br>JAN 31 1996  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>John Davidson-Randall  |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

68760

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

85000 00

Amended line 7 FCHD, JD, as per Funeral Director

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04879

|  |  |  |  |   |                                     |   |   |   |  |   |  |
|--|--|--|--|---|-------------------------------------|---|---|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Lottie Roberta Wilt</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>1</b> DAY <b>22</b> YEAR <b>96</b>   |                                     | 3. TIME OF DEATH<br><b>10:10A M</b>   |   |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>214-34-7197</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>85</b> YRS.  |                                     | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Jan. 22, 1910</b>                                 |   | 8. BIRTHPLACE (State or Foreign Country)<br><b>Virginia</b>   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Meridian Nursing Center</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Frederick</b>   |                                     |   | 9c. COUNTY OF DEATH<br><b>Frederick</b>   |   |  |   |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Frederick</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Frederick</b>   |                                     |   | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |   |  |   |  |
| 10e. STREET AND NUMBER<br><b>400 North Avenue</b>  |  |  |  | 10f. ZIP CODE<br><b>21701</b>   |                                     |   | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |                                     |   | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                         |   |  |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+) <b></b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>  |                                     |   | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Own home</b>   |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William Cooper</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Bessie Frye</b>   |                                     |   |   |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Patricia W. Grimes</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>501 East Main Street, Middletown, Maryland 21769</b>  |                                     |   |   |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Mt. Olivet Cemetery Jan. 25, 1996 Frederick, Maryland</b>  |  |   | 20c. LOCATION — City or Town, State |   |   |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Robert C. C. [Signature]</b> M00021  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Keeney and Basford Funeral Home<br/>106 East Church Street, Frederick, Md. 21701</b>   |                                     |   |   |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Bilateral lower lobe pneumonia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. <b></b> DUE TO (OR AS A CONSEQUENCE OF):<br>c. <b></b> DUE TO (OR AS A CONSEQUENCE OF):<br>d. <b></b> |  |  |  |   |                                     |   |   | Approximate Interval Between Onset and Death<br><b>1 week</b>   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Alzheimer's disease</b>   |  |  |  |   |                                     |   |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |  |   |                                     |   |   |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |                                     |   |   |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |                                     | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |                                     |   |   |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |                                     |   |   |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Ali J. Afrocuteh MD</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D 35183</b>   |                                     |   | 29d. DATE SIGNED (Month, Day, Year)<br><b>1/22/96</b>   |   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Ali J. Afrocuteh 300 W 9th St Frederick, MD</b>  |  |  |  |   |                                     |   |   |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>JAN 26 1996</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>   |                                     |   |   |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

250 70 2/3

Amended #10e, MRT, Montgomery County 2/8/96

1 -  
FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04880

|  |  |  |  |   |  |   |                                   |   |  |
|--|--|--|--|---|--|---|-----------------------------------|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Charles Darwin Andersen  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>February 5, 1996  |  | 3. TIME OF DEATH<br>7:30PM M  |                                   |   |  |
| 4. SOCIAL SECURITY NUMBER<br>393-07-5467   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>82 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>April 17, 1913   |                                   | 8. BIRTHPLACE (State or Foreign Country)<br>Illinois  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Rockville Nursing Home   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Rockville  |  |   | 9c. COUNTY OF DEATH<br>Montgomery |   |  |
| 10a. STATE<br>Maryland   |  |  |  | 10b. COUNTY<br>Montgomery   |  | 10c. CITY, TOWN OR LOCATION<br>Bethesda   |                                   | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>8619<br>8619 Lancaster Drive   |  |  |  | 10f. ZIP CODE<br>20814  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>United States  |                                   |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>World War II  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                                |                                   |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>College (1-4 or 5+)<br>5+  |  | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Personnel Officer  |  | 15b. KIND OF BUSINESS/INDUSTRY<br>Veterans Administration   |  |   |                                   |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Hans Thomas Andersen  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Anna Abelmann  |  |   |                                   |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Nancy L. Stoeber   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3712 N. Road 3 West, Monte Vista, Colorado 81144   |  |   |                                   |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>February 14, 1996<br>Arlington National Cemetery  |  | 20c. LOCATION — City or Town, State<br>Arlington, Virginia  |  |   |                                   |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>David E. Perry  |  | M00803   |  | 22. NAME AND ADDRESS OF FACILITY<br>Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814  |  |   |                                   |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Cardiomyopathy</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Approximate Interval Between Onset and Death<br>Month |  |  |  |   |  |   |                                   |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Congestive Heart Failure</u>  |  |  |  |   |  |   |                                   |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |                                   |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |                                   | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>140   |  | 29c. LICENSE NUMBER<br>D20516   |  | 29d. DATE SIGNED (Month, Day, Year)<br>February 6, 1996   |                                   |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Joel R. Schulman, M.D. 9410 Old Georgetown Road, Bethesda, Maryland 20814   |  |  |  |   |  |   |                                   |   |  |
| 31. DATE FILED (Month, Day, Year)<br>FEB 08 1996   |  | 32. REGISTRAR'S SIGNATURE<br>Julia Anderson Randall  |  |   |  |   |                                   |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

103020 12

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04881

|  |  |  |  |   |  |  |  |   |  |
|--|--|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>IRMA MAE AHERN</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>FEBRUARY</b> DAY <b>8</b> YEAR <b>1996</b>   |  |  |  | 3. TIME OF DEATH<br><b>6:30 P M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216-20-0449</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>71</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>May 21 1924</b> |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>West Virginia</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Sacred Heart Hospital</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Cumberland</b>  |  |  |  | 9c. COUNTY OF DEATH<br><b>Allegany</b>  |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |  |  |   |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Garrett</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Swanton</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br><b>17078 Maryland Highway</b>  |  |  |  | 10f. ZIP CODE<br><b>21561</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>Unknown</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Westvaco Employee</b>  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Paper Manufacture</b>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>George E. Bever</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Edith E. Fox</b>  |  |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Bruce Ahern</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>17078 Maryland Highway Swanton, Md. 21561</b>   |  |  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Bever Cemetery 2-12-96</b>                             |  | DATE<br><b>Swanton, Md.</b>   |  | 20c. LOCATION — City or Town, State                          |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Wayne Bol</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Boal Funeral Service<br/>111 Church St. Westernport, Md. 21562</b>   |  |  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Immediate Cause (Final disease or condition resulting in death) →</b><br><b>Coe pulmonary</b><br><b>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b><br><b>Emphysema</b><br><b>pulmonary fibrosis</b> |  |  |  |   |  |  |  | Approximate Interval Between Onset and Death<br><b>10 years</b><br><b>10 YEARS</b><br><b>10 YEARS</b>                                   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Idiopathic pulm fibrosis</b>  |  |  |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>  |  |  |  |   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br><input checked="" type="checkbox"/> HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>                              |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |
|  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  |   |  |
|  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> 1. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> 2. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Richard G. Schmitt</i>  |  |  |  | 29c. LICENSE NUMBER<br><b>D26333</b>  |  |
|  |  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>FEBRUARY 12 1996</b>  |  |  |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Richard G. Schmitt</b>   |  |  |  | 31. DATE FILED (Month, Day, Year)<br><b>FEB 13 1996</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John A. ...</i>   |  |

10028 C



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 96 04882

Physician  
/Medical  
ExaminerFuneral  
Director

|  |  |   |  |   |  |   |  |  |  |  |  |
|--|--|---|--|---|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>FLORENCE ALLEN</b>  |  |   |  | 2. Date of Death<br>Month <b>FEBRUARY</b> Day <b>3</b> Year <b>1996</b>   |  |   |  | 3. Time of Death<br><b>4:06PM</b>  |  |  |  |
| 4a. Facility Name (If not Institution, give street and number)<br><b>Prince George's Hospital Center</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Cheverly</b>   |  |   |  | 4c. County of Death<br><b>Prince George's</b>  |  |  |  |
| 5. Social Security Number<br><b>577-36-7503</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>67</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>Oct. 2, 1928</b>                        |  | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b>                                    |  |  |  |
| Usual Residence of Decedent  |  |   |  |   |  |   |  |  |  |  |  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Prince George's</b>   |  | 10c. City, Town or Location<br><b>Bladensburg</b>   |  |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |  |
| 10e. Street and Number<br><b>5402 Taylor Street</b>  |  |   |  | 10f. Zip Code<br><b>20710</b>   |  |   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br><b>12</b><br>Elementary/Secondary (0-12) College (1-4 or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Secretary</b>   |  |   |  | 16b. Kind of Business/Industry<br><b>Private Industry</b>                                      |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Emanuel Walker Fitzgerald</b>  |  |   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Bessie Lee Derflinger</b> |  |  |  |  |  |
| 19e. Informant's Name/Relationship (Type, Print)<br><b>Jeff Edwards / Son</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8701 Cheshire Court, Jessup, Maryland 20794</b>   |  |   |  |  |  |  |  |
| 20e. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory 02/05/96</b>  |  |   |  | 20c. Location - City or Town, State<br><b>Alexandria, Virginia</b>                             |  |  |  |
| 21. Signature of Funeral Service Licensee<br><i>W.B. Giese</i>   |  |   |  | 22. Name and Address of Facility<br><b>Francis Gasch's Sons Funeral Home, P.A.<br/>4739 Baltimore Avenue, Hyattsville, MD 20781</b>   |  |   |  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <i>Acute Respiratory Failure</i><br/>Due to (or as a consequence of):</p> <p>b. <i>Pneumonia</i><br/>Due to (or as a consequence of):</p> <p>c. <i>Congestive Heart Failure</i><br/>Due to (or as a consequence of):</p> <p>d. <i>Chronic Obstructive Pulmonary Disease</i></p> </div> <div style="width: 15%;"> <p>Approximate Interval Between Onset and Death</p> <p><b>3 Weeks</b></p> <p><b>3 Weeks</b></p> <p><b>3 Weeks</b></p> <p><b>20 Years</b></p> </div> </div> |  |   |  |   |  |   |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|  |  |   |  |   |  |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|  |  |   |  |   |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  |   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |  | 28d. Describe how injury occurred  |  |
|  |  |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                   |  |  |  |
| 29e. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |   |  |   |  |  |  |  |  |
| 29b. Signature and title of certifier<br><i>Louis Steinberg MD</i>   |  |   |  | 29c. License number<br><b>D12015</b>  |  |   |  | 29d. Date signed (Month, Day, Year)<br><b>2-5-96</b>   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Louis Steinberg MD 6492 Landover Rd Landover Md 20785</b>   |  |   |  |   |  |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 07 1996</b>  |  |   |  | 32. Registrar's Signature<br><i>John Anderson</i>   |  |   |  |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 96 04883   |  |
|--|--|--|--|--|--|
| 1 - FOR STATE REGISTRAR  |  |  |  | REG. NO.   |  |
| 1. DECEDENT'S NAME (First, Middle, Last)   |  |  |  | 2. DATE OF DEATH   |  |
| Margaret Mae Acton   |  |  |  | February 1, 1996   |  |
| 3. TIME OF DEATH   |  |  |  | 11:10 P M  |  |
| 4. SOCIAL SECURITY NUMBER  |  | 5. SEX   |  | 6. AGE (In yrs. last birthday)   |  |
| 577-36-3859  |  | 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 67 YRS.  |  |
| 7. DATE OF BIRTH   |  | 8. BIRTHPLACE (State or Foreign Country)                             |  | 9. COUNTY OF DEATH   |  |
| June 10, 1928  |  | Maryland   |  | Prince George's  |  |
| 10. FACILITY NAME (If not institution, give street and number)   |  |  |  | 11. CITY, TOWN OR LOCATION OF DEATH  |  |
| 4701 Tuckerman Street  |  |  |  | Riverdale  |  |
| 12. RESIDENCE OF DECEDENT  |  |  |  | 13. INSIDE CITY LIMITS?  |  |
| 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION   |  |  |  | 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| Maryland Prince George's Riverdale   |  |  |  |  |  |
| 14. STREET AND NUMBER  |  |  |  | 15. ZIP CODE   |  |
| 4701 Tuckerman Street  |  |  |  | 20737  |  |
| 16. CITIZEN OF WHAT COUNTRY?   |  |  |  | 17. RACE — American Indian, Black, White, etc.   |  |
| USA  |  |  |  | Specify: White   |  |
| 18. MARITAL STATUS   |  |  |  | 19. WAS DECEDENT EVER IN U.S. ARMED FORCES?  |  |
| 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  |  |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |
| 20. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)   |  |  |  | 21. RACE — American Indian, Black, White, etc.   |  |
| 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  |  |  | Specify: White   |  |
| 22. DECEDENT'S EDUCATION (Specify only highest grade completed)  |  |  |  | 23. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)  |  |
| Elementary/Secondary (0-12) College (1-4 or 5+)  |  |  |  | Administration Clerk   |  |
| 24. DECEDENT'S USUAL BUSINESS/INDUSTRY   |  |  |  | 25. KIND OF BUSINESS/INDUSTRY  |  |
| 9  |  |  |  | Duron Paints & Wall Covering   |  |
| 26. FATHER'S NAME (First, Middle, Last)  |  |  |  | 27. MOTHER'S NAME (First, Middle, Maiden Surname)  |  |
| James Paul McKenney  |  |  |  | Pauline Marie Lecklighters   |  |
| 28. INFORMANT'S NAME (Type/Print)  |  |  |  | 29. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)   |  |
| Walter Wyatt Acton, Jr.  |  |  |  | 4701 Tuckerman St. Riverdale, Md. 20737  |  |
| 30. METHOD OF DISPOSITION  |  |  |  | 31. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)   |  |
| 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | Maryland Veterans Cemetery 2/6/96 Cheltenham, Md.  |  |
| 32. SIGNATURE OF FUNERAL SERVICE LICENSEE  |  |  |  | 33. NAME AND ADDRESS OF FACILITY   |  |
| Francis Gasch  |  |  |  | Francis Gasch's Sons Funeral Home 4739 Baltimore Ave., Hyattsville, Md. 20781  |  |
| 34. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  | 35. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. metastatic carcinoma  |  |  |  |  |  |
| b. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |
| 36. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  | 37. WAS AN AUTOPSY PERFORMED?  |  |
|  |  |  |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |
| 38. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>  |  |  |  | 39. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?   |  |
|  |  |  |  | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 40. WAS CASE REFERRED TO MEDICAL EXAMINER?   |  |  |  | 41. PLACE OF DEATH (Check only one)  |  |
| 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |
| 42. MANNER OF DEATH  |  |  |  | 43. DATE OF INJURY (Month, Day, Year)  |  |
| 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined       |  |  |  | 28b. TIME OF INJURY 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |
| 44. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 45. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |
| 28a. PLACE OF INJURY   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |
|  |  |  |  |  |  |
| 46. CERTIFIER (Check only one)   |  |  |  | 47. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |
| 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |  |
| 48. SIGNATURE AND TITLE OF CERTIFIER   |  |  |  | 49. LICENSE NUMBER   |  |
| Marden O. Wheelton   |  |  |  | D23943   |  |
| 50. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  |  |  |  | 51. DATE SIGNED (Month, Day, Year)   |  |
| MARTIN D WHEELTON 5225 Greenway Ct On Greenbelt MD   |  |  |  | 2/2/96   |  |
| 52. DATE FILED (Month, Day, Year)  |  |  |  | 53. REGISTRAR'S SIGNATURE  |  |
| FEB 05 1996  |  |  |  | John D. ...  |  |

88000 00

2000 00 00 00 00 00

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR   |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 96 04884  |  |   |  |   |  |
|---|--|--|--|--|--|--|--|---|--|---|--|---|--|
| CERTIFICATE OF DEATH  |  |  |  | REG. NO.   |  |  |  |   |  |   |  |   |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>AGNES A. ALLEN</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>FEBRUARY</b> DAY <b>1</b> YEAR <b>1996</b>  |  |  |  | 3. TIME OF DEATH<br><b>8 P.M.</b>   |  |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>248-56-1338</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>77</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>                         |  | IF UNDER 24 HRS.<br>HOURS <b></b> MIN. <b></b>  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Dec. 5, 1918</b> |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>South Carolina</b> |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Southern Maryland Hospital</b>   |  |  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Clinton</b>                  |  |   |  | 9c. COUNTY OF DEATH<br><b>Prince Georges</b>                  |  |   |  |
| RESIDENCE OF DECEDENT   |  |  |  |  |  |  |  |   |  |   |  |   |  |
| 10a. STATE<br><b>MD</b>   |  | 10b. COUNTY<br><b>Prince Georges</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Camp Springs</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |   |  |   |  |
| 10e. STREET AND NUMBER<br><b>7106 Berkshire Drive</b>   |  |  |  | 10f. ZIP CODE<br><b>20748</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Black</b>                      |  |   |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+) <b></b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Home maker</b>   |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>self</b>   |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Adam Asbury</b>   |  |  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Orie Brown</b> |  |   |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Ora Patterson/Daughter</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7106 Berkshire Dr., Camp Springs, MD 20748</b>   |  |  |  |   |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Washington Nat'l. Cem. 2/9</b>   |  |  |  | 20c. LOCATION — City or Town, State<br><b>Suitland, MD</b>                                      |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>J.P. Marshall</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Marshall's Funeral Home, Inc.<br/>4308 Suitland Rd., Suitland, MD 20746</b>   |  |  |  |   |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Generalized Sepsis</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>urinary tract</b><br><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br><br>Approximate Interval Between Onset and Death<br><b>2 wks</b><br><b>2- wks</b> |  |  |  |  |  |  |  |   |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>pneumonia</b><br><b>Coronary Heart Failure</b><br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/></b>   |  |  |  |  |  |  |  |   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be ascertained  |  |  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  | 28d. DESCRIBE HOW INJURY OCCURED                              |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Lucio S. Villa-Real</i>  |  |  |  | 29c. LICENSE NUMBER<br><b>DISTB</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>2/1/96</b>          |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>LUCIO S. VILLA-REAL, M.D., 2 ST. PATRICK'S DRIVE, WILDER, MD 20603</b>  |  |  |  |  |  |  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 05 1996</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John H. ...</i>  |  |  |  |   |  |   |  |   |  |

1902. 21

1902. 21

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04885

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

RUTH

ANDREWS

2. Date of Death

February 4, 1996

3. Time of Death

6:05AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

MD State Anatomy Board

4b. City, Town, or Location of Death

Baltimore, MD

4c. County of Death

Baltimore County

5. Social Security Number

562-32-6010A

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Feb. 13, 1920

9. Birthplace (State or Foreign Country)

Gary W. VA

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince Georges

10c. City, Town or Location

Clinton, Maryland

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

9211 Stuart Lane

10f. Zip Code

20735

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

9

Collega (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Domestic Worker

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

John W. Smith

18. Mother's Name (First, Middle, Maiden Surname)

Cora Franklin

19a. Informant's Name/Relationship (Type, Print)

Joseph Smith

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3409 Waynewood Road Ft. Washington, MD 20744

20a. Method of Disposition

☐ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Harmony Meorial Park

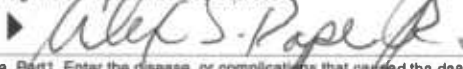
Date

2-9-96

20c. Location - City or Town, State

Landover, MD.

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Alexander S. Pope Funeral Homes

5538 Marlboro Pike Forestville, Md. 20747

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Severe atherosclerotic coronary heart dis.

years.

Due to (or as a consequence of):

b. Intractable congestive heart failure.

Months.

Due to (or as a consequence of):

c. END stage of renal disease, on Hemodialysis.

Months.

Due to (or as a consequence of):

d. Aortoiliac occlusive disease, gangrene

Months.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

chronic cholecystitis and gall stone disease.

Hypertensive cardiovascular disease

presacral decubitus ulcer disease.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☒ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

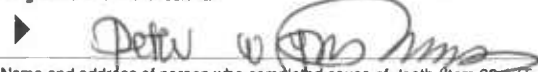
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D12884

29d. Date signed (Month, Day, Year)

Feb. 8 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PETER W. YIM M.D. 7900 OLD BRANCH AVE. SUITE 101, CLINTON, MARYLAND 20735

31. Date filed (Month, Day, Year)

FEB 09 1996

32. Registrar's Signature

State  
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

2000

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04886

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

|  |  |  |  |   |  |  |  |  |  |   |  |
|--|--|--|--|---|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>PAULINE VIRGINIA BAER</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>FEBRUARY</b> DAY <b>9</b> YEAR <b>1996</b>   |  | 3. TIME OF DEATH<br><b>11:08 A M</b>   |  |  |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>190 28 8161</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>60</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Aug. 25, 1935</b>                      |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Pa.</b>   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Sacred Heart Hospital</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Cumberland</b>  |  |  | 9c. COUNTY OF DEATH<br><b>Allegany</b> |  |  |   |  |
| RESIDENCE OF DECEDENT  |  |  |  | 10a. STATE<br><b>Pa.</b>  |  | 10b. COUNTY<br><b>Somerset Co.</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Meyersdale</b>   |  |   |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 10e. STREET AND NUMBER<br><b>RD-4</b>   |  | 10f. ZIP CODE<br><b>15552</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>       |  |  |  |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b><br>College (1-4 or 5+) <b>College (1-4 or 5+)</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Home</b>   |  |  |  |  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Allen C. Decker</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Cora E. Bockes</b>  |  |  |  |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Guy P. Baer</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>RD-4, Meyersdale, Pa. 15552</b>   |  |  |  |  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Union Cemetery Feb. 12, 1996</b>   |  | DATE<br><b>Feb. 12, 1996</b>  |  | 20c. LOCATION — City or Town, State<br><b>Meyersdale, Pa.</b>                    |  |  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br> <b>ED-011249-L</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>W. R. Price Funeral Home, Inc.<br/>325 Main St., Meyersdale, Pa. 15552</b>   |  |  |  |  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>MULTIPLE ORGAN FAILURE</b><br><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br><b>SEPTIC SHOCK</b><br><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br><b>FECAL PERITONITIS</b><br><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br><b>COLON PERFORATION DUE TO PSEUDOMEMBRANOUS ENTEROCOLITIS</b> |  |  |  |   |  |  |  | Approximate interval Between Onset and Death<br><b>48 HRS.</b><br><br><b>unknown</b><br><br><b>unknown</b><br><br><b>unknown</b> |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>ADMITTED MASSIVE GI BLEEDING</b><br><b>FROM SIGMOID DIVERTICULOSIS</b><br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/></b>  |  |  |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                            |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |  |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  |  |  |   |  | 29c. LICENSE NUMBER<br><b>D11136</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>FEBRUARY 9, 1996</b>   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>ANDREW STASKO, MD. 924 SETON DRIVE CUMBERLAND, MD. 21505</b>   |  |  |  |   |  |  |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 14 1996</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>  |  |  |  |  |  |   |  |

2381

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR   |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 96 04887  |  |   |  |   |  |   |  |
|---|--|--|--|--|--|---|--|---|--|---|--|---|--|---|--|
| CERTIFICATE OF DEATH  |  |  |  | REG. NO.   |  |   |  |   |  |   |  |   |  |   |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br>GARRY T. BOWDEN   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>February 3, 1996   |  |   |  | 3. TIME OF DEATH<br>2:17 M  |  |   |  |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br>214-42-8438  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>51 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS                        |  | IF UNDER 24 HRS.<br>HOURS MIN.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>March 1, 1944 |  | 8. BIRTHPLACE (State or Foreign Country)<br>Md.   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>PENINSULA REGIONAL MEDICAL CENTER   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>SALISBURY   |  |   |  | 9c. COUNTY OF DEATH<br>WICOMICO   |  |   |  |   |  |   |  |
| RESIDENCE OF DECEDENT   |  |  |  |  |  |   |  |   |  |   |  |   |  |   |  |
| 10a. STATE<br>Md.   |  | 10b. COUNTY<br>Wicomico  |  | 10c. CITY, TOWN OR LOCATION<br>Sharptown   |  |   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |   |  |   |  |   |  |
| 10e. STREET AND NUMBER<br>P.O. Box 513  |  |  |  | 10f. ZIP CODE<br>21861   |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  |   |  |   |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                                |  |   |  |   |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12   |  | College (1-4 or 5+)<br>College (1-4 or 5+)   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Power House Employee  |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>E.I. DuPont Co.   |  |   |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Thomas F. Bowden   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Louise Cooper Bowden  |  |   |  |   |  |   |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Mary Louise Bowden  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>P.O. Box 513 Sharptown, Md. 21861   |  |   |  |   |  |   |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Firemen's Cemetery  |  | DATE<br>2-6  |  | 20c. LOCATION — City or Town, State<br>Sharptown, Md. |  |   |  |   |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>William M. Short   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Short Funeral Home, Inc.<br>13 E. Grove St. Delmar, De. 19940  |  |   |  |   |  |   |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive Heart Failure<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |  |  |   |  |   |  |   |  | Approximate Interval Between Onset and Death<br>Years   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |  |   |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |  |  |  |   |  |   |  |   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |   |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |  |  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M                              |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                |  | 28d. DESCRIBE HOW INJURY OCCURRED                       |  |   |  |   |  |
|   |  |  |  | 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                    |  |   |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |  |   |  |   |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>John Davidson-Rodall   |  |  |  | 29c. LICENSE NUMBER<br>34168   |  |   |  | 29d. DATE SIGNED (Month, Day, Year)<br>2/5/96   |  |   |  |   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>560 RIVERSIDE DR. B101 (FEBRUARY HIRSHMAN, MD.) SALISBURY, MD 21801  |  |  |  |  |  |   |  |   |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>FEB 06 1996  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>John Davidson-Rodall  |  |   |  |   |  |   |  |   |  |   |  |



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION


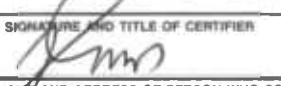
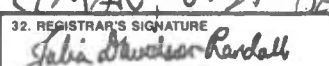
| 1 - FOR STATE REGISTRAR  |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |                                |  |  | 96 04888  |  |
|--|--|--|--|---|--------------------------------|--|--|---|--|
| CERTIFICATE OF DEATH   |  |  |  | REG. NO.  |                                |  |  |   |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>EILEEN AUDREY BAUGHMAN</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>FEBRUARY 5, 1996</b>   |                                |  |  | 3. TIME OF DEATH<br><b>2:40 P.M.</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>300-22-5092</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br><b>69</b> YRS. | IF UNDER 1 YEAR<br>MONTHS DAYS  | IF UNDER 24 HRS.<br>HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year)<br><b>OCTOBER 5 1926</b>                     |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>West Virginia</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>MALCOLM GROW USAF MEDICAL CENTER</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>CLINTON</b>   |                                |  |  | 9c. COUNTY OF DEATH<br><b>PRINCE GEORGES</b>  |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |                                |  |  |   |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Prince George</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>AAFB</b>  |                                |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br><b>4353 D. Washington Court</b>  |  |  |  | 10f. ZIP CODE<br><b>20762</b>   |                                | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>                            |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |                                | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>       |  |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b><br><b>12th</b>   |  | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>   |  | 15b. KIND OF BUSINESS/INDUSTRY<br><b>Own Home</b>   |                                |  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Wayman Freeman</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Etta Mae Guthrie</b>  |                                |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Nancy A. Baughman</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9 Roby Street, Nashua, N.H. 03060</b>   |                                |  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Lee Crematory Feb 6, 1996</b>  |  | DATE<br><b>FEB 6, 1996</b>  |                                | 20c. LOCATION — City or Town, State<br><b>Clinton, Maryland</b>                  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Lee Funeral Home, Inc 6633 Old Alexandria Ferry Rd, Clinton, Md 20735</b>  |                                |  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. PNEUMONIA</b><br><b>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b><br>b. <b>SQUAMOUS CELL CARCINOMA OF LUNG</b><br>c. <b>CONGESTIVE HEART FAILURE</b><br>d. _____ |  |  |  |   |                                |  |  | Approximate Interval Between Onset and Death  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>   |  |  |  |   |                                |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |                                |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |                                | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
|  |  | 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |                                | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)     |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |                                |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  |  |  | 29c. LICENSE NUMBER<br><b>D 37489</b>   |                                | 29d. DATE SIGNED (Month, Day, Year)<br><b>FEBRUARY 5, 1996</b>                   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>LARRY N. JOHNSON, MAJ, USAF, MC</b>  |  |  |  | <b>1050 WEST PERIMETER RD ANDREWS AIR FORCE BASE MD 20762-6600</b>  |                                |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 14 1996</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>  |                                |  |  |   |  |



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR   |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 96 04889  |  |   |  |
|---|--|--|--|--|--|---|--|---|--|---|--|
| CERTIFICATE OF DEATH  |  |  |  | REG. NO.   |  |   |  |   |  |   |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>CATHERINE MILLER BEAN</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>FEB.</b> DAY <b>11</b> YEAR <b>1996</b>   |  |   |  | 3. TIME OF DEATH<br><b>7:55 A M</b>   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>350-20-2617</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>78</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN. <b></b>                       |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>March 19, 1917 Maryland</b>                              |  | 8. BIRTHPLACE (State or Foreign Country)  |  |
| 9a. FACILITY NAME (If not Institution, give street and number)<br><b>Washington Adventist Hospital</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Takoma Park</b>  |  |   |  | 9c. COUNTY OF DEATH<br><b>Montgomery</b>  |  |   |  |
| RESIDENCE OF DECEDENT   |  |  |  |  |  |   |  |   |  |   |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Prince George's</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Clinton</b>  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |   |  |   |  |
| 10e. STREET AND NUMBER<br><b>9403 Brandywine Road</b>   |  |  |  | 10f. ZIP CODE<br><b>20735</b>  |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Caucasian</b>                  |  |   |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12th</b>   |  | 15a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>            |  | 15b. KIND OF BUSINESS/INDUSTRY<br><b>Home</b>  |  |   |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Blossie Keuberth Miller</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Violet Lyons</b>   |  |   |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Robert Bean</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9403 Brandywine Rd. Clinton, Maryland 20735</b>  |  |   |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Resurrection Cemetery</b>                              |  | 20c. LOCATION — City or Town, State<br><b>Clinton, Maryland</b>  |  |   |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Lee Funeral Home, Inc.<br/>6633 Old Alexandria Ferry Rd Clinton, Md 20735</b>   |  |   |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>COPD</b><br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br><br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |  |  |   |  | Approximate Interval Between Onset and Death<br><b>10 YRS</b>   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br> MD  |  |   |  | 29c. LICENSE NUMBER<br><b>020391</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>FEBRUARY 11, 1996</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>JEFFREY KELMAN, 6525 BELCAST RD, HYATTSVILLE, MD 20782</b>  |  |  |  |  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 14 1996</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |   |  |   |  |   |  |

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. STATE REGISTRAR  |  |   |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 96 04890  |  |   |  |
|---|--|---|--|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)  |  |   |  | 2. DATE OF DEATH   |  |   |  | 3. TIME OF DEATH  |  |   |  |
| ANNA BURNS  |  |   |  | FEBRUARY 8, 1996   |  |   |  | 1155 M  |  |   |  |
| 4. SOCIAL SECURITY NUMBER   |  | 5. SEX  |  | 6. AGE (In yrs. last birthday)   |  | IF UNDER 1 YEAR   |  | IF UNDER 24 HRS.  |  | 7. DATE OF BIRTH  |  |
| 146-24-6640   |  | 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 63 YRS.  |  | MONTHS DAYS   |  | HOURS MIN.  |  | 4-29-32   |  |
| 9a. FACILITY NAME (If not institution, give street and number)  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH  |  |   |  | 9c. COUNTY OF DEATH   |  |   |  |
| ATLANTIC GENERAL HOSPITAL   |  |   |  | BERLIN   |  |   |  | WORCESTER   |  |   |  |
| 10a. STATE  |  |   |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION   |  | 10d. INSIDE CITY LIMITS?  |  |   |  |
| Md.   |  |   |  | WORCESTER  |  | BERLIN  |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |   |  |
| 10e. STREET AND NUMBER  |  |   |  | 10f. ZIP CODE  |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?   |  |   |  |
| 24 CAMELOT CIRCLE   |  |   |  | 21811  |  |   |  | USA   |  |   |  |
| 11. MARITAL STATUS  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN?   |  | 14. RACE — American Indian, Black, White, etc.  |  |   |  |   |  |
| 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married  |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | Specify: WHITE  |  |   |  |   |  |
| 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | IF YES, GIVE WAR OR DATES   |  | If yes, specify Cuban, Mexican, Puerto Rican, etc.   |  |   |  |   |  |   |  |
| 15. DECEDENT'S EDUCATION  |  |   |  | 15a. DECEDENT'S USUAL OCCUPATION   |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |
| (Specify only highest grade completed)  |  |   |  | (Give kind of work done during most of working life. Do NOT use retired.)  |  |   |  |   |  |   |  |
| Elementary/Secondary (0-12)   |  |   |  | College (1-4 or 5+)  |  |   |  | CORP. SECRETARY   |  |   |  |
| 12  |  |   |  |  |  |   |  | PUBLIC UTILITY  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)  |  |   |  |   |  |   |  |
| GEORGE SCHAPER  |  |   |  | ANN SCHAPER  |  |   |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)                                  |  |   |  |   |  |   |  |
| ROBERT BURNS  |  |   |  | 24 CAMELOT CIRCLE BERLIN, MD., 21811   |  |   |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)   |  | DATE   |  | 20c. LOCATION — City or Town, State   |  |   |  |   |  |
| 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State   |  | SOMERSET HILLS MEM. PK. 2-14  |  | 2-14   |  | BASKING RIDGE, NJ   |  |   |  |   |  |
| 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |   |  |  |  |   |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE   |  |   |  | 22. NAME AND ADDRESS OF FACILITY   |  |   |  |   |  |   |  |
|   |  |   |  | ULLRICH FUNERAL HOME BERLIN, MD., 2  |  |   |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. |  |   |  |  |  |   |  | Approximate Interval Between Onset and Death                            |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Intracerebral bleed  |  |   |  |  |  |   |  | 2 days  |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |  |  |   |  |   |  |   |  |
| b. DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |  |  |   |  |   |  |   |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |  |  |   |  |   |  |   |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |  |  |   |  |   |  |   |  |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  |   |  |  |  |   |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?  |  |   |  |
|   |  |   |  |  |  |   |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |   |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?   |  |   |  |  |  |   |  | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO            |  |   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |   |  |  |  |   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?  |  | 26. PLACE OF DEATH (Check only one)   |  | 27. MANNER OF DEATH  |  | 28a. DATE OF INJURY   |  | 28b. TIME OF INJURY   |  | 28c. INJURY AT WORK?  |  |
| 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA |  | OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation   |  | M   |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 2 <input type="checkbox"/> Accident   |  | 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28b. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  | 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined |  | Home  |  |   |  |
| 4 <input type="checkbox"/> Homicide   |  |   |  |  |  |   |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)   |  | 29b. LICENSE NUMBER   |  | 29c. DATE SIGNED (Month, Day, Year)  |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)   |  | 31. DATE FILED (Month, Day, Year)                                       |  | 32. REGISTRAR'S SIGNATURE   |  |
| 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                   |  | D47676  |  | 2/8/96   |  | BSHER TOULEIMAT 9733 HEALTHWAY DRIVE, BERLIN, MD. 21811                               |  | FEB 12 1996   |  |   |  |
| 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  |  |   |  |   |  |   |  |

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DIVISION OF VITAL RECORDS, P.O. BOX 687600 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR



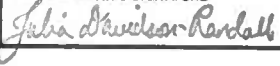
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR  |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 96 04891   |  |   |  |
|--|--|--|--|---|--|--|--|--|--|---|--|
| CERTIFICATE OF DEATH   |  |  |  | REG. NO.  |  |  |  |  |  |   |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ASBURY FRANKLIN BUNDRICK, JR.</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Feb. 1, 1996</b>   |  |  |  | 3. TIME OF DEATH<br><b>7:40 A M</b>  |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>250-58-3797</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>57</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>June 7, 1938</b>                    |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>South Carolina</b>                          |  |   |  |
| 9a. FACILITY NAME (If not Institution, give street and number)<br><b>116 Brannan Road</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Aberdeen</b>  |  |  |  | 9c. COUNTY OF DEATH<br><b>Harford</b>  |  |   |  |
| 10a. STATE<br><b>Maryland</b>  |  |  |  | 10b. COUNTY<br><b>Harford</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Aberdeen</b>                                   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br><b>116 Brannan Road</b>  |  |  |  | 10f. ZIP CODE<br><b>21001</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>1955 - 1961</b>  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>white</b>       |  |  |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 11</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Electrician</b>   |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Construction</b>                                      |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Asbury Franklin Bundrick, Sr.</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mary Lou Mettze</b>   |  |  |  |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Carolyn S. Bundrick</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>116 Brannan Road, Aberdeen, Maryland 21001</b>  |  |  |  |  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Bel Air Memorial Gardens 1/5/96</b>  |  | 20c. LOCATION — City or Town, State<br><b>Bel Air, Maryland</b>   |  |  |  |  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Howard K. McComas III</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Howard K. McComas III Funeral Home, P.A.<br/>1317 Cokesbury Road, Abingdon, Md. 21009</b>  |  |  |  |  |  |   |  |
| 23. PART I. Enter the disease or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b><br><b>a. CA of metastatic melanoma</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d.</b> |  |  |  |   |  |  |  | Approximate Interval Between Onset and Death   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>  |  |  |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |  |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURED   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>John R. Yea MD</i>   |  |   |  |  |  | 29c. LICENSE NUMBER<br><b>D12190</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>2/5/96</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)<br><b>JOHN R. Yea, Harford County, MD</b>   |  |  |  |   |  |  |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 5 1996</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Andrew Randall</i>   |  |  |  |  |  |   |  |

10840 20

Handwritten signature or text at the bottom right.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR   |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO.  |  |  |  |
|--|--|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Edward Rapheal Bloom   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>FEB 1st 1996  |  | 3. TIME OF DEATH<br>04:00PM M   |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br>190-26-7122   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>62 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>04-05-1933   |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>991 Bern Drive   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Havre de Grace   |  | 9c. COUNTY OF DEATH<br>Harford  |  |  |  |
| RESIDENCE OF DECEDENT  |  |   |  |   |  |   |  |  |  |
| 10a. STATE<br>MD   |  | 10b. COUNTY<br>Harford  |  | 10c. CITY, TOWN OR LOCATION<br>Havre De Grace   |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO       |  |  |  |
| 10e. STREET AND NUMBER<br>991 Burn Drive   |  |   |  | 10f. ZIP CODE<br>21078  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>MD Nat. Guard |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                                       |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Security Guard                                   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>State of Maryland   |  |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Hubert Fitz   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Annie C. Bloom   |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Mr. Terry E. Bloom   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2102 Williams Dr., Havre de Grace, MD 21078  |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Mt. Erin Cemetery 2/6  |  | 20c. LOCATION — City or Town, State<br>Havre de Grace, MD   |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>Mitchell-Smith Funeral Home, P.A.<br>Havre de Grace, MD 21078-3197  |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute Coronary Artery Disease<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. ASCVD<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |   |  |   |  | Approximate Interval Between Onset and Death   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>S/P Coronary Artery Bypass Disease<br>CHF  |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |   |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | HOSPITAL:<br>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA   |  | OTHER:<br>4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                      |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br> DME  |  | 29c. LICENSE NUMBER<br>D21809   |  | 29d. DATE SIGNED (Month, Day, Year)<br>2-1-96  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>G.S. PRABHU M.D. 1810 BELAIR RD # 102 FALLSTON MD. 21047 410-879-6564   |  |   |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>FEB 5 1996  |  |   |  | 32. REGISTRAR'S SIGNATURE<br>  |  |   |  |  |  |

SEP 10 1961

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04893

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

SALLIE MARGARET BEAVERS

2. Date of Death

Month Day Year  
FEBRUARY 1, 1996

3. Time of Death

7:15 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

4047 CHAPEL ROAD

4b. City, Town, or Location of Death

HAVRE DE GRACE

4c. County of Death

HARFORD

5. Social Security Number

216-24-8567

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 6, 1909

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Harford

10c. City, Town or Location

Havre de Grace

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4047 Chapel Road

10f. Zip Code

21078

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
if Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
9

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Joseph Harrison

18. Mother's Name (First, Middle, Maiden Surname)

Rachel Deskins

19a. Informant's Name/Relationship (Type, Print)

Ms. Jackie Harrison, Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4 Lexington Court, North East, MD 21901

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Bel Air Memorial Gardens 02/06

Date

20c. Location - City or Town, State

Bel Air, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Mitchell-Smith Funeral Home, P.A.  
Havre de Grace, MD 21078-319723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. HEAD INJURY

Due to (or as a consequence of):

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown25. Was case referred to medical  
examiner?  
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)

FEB 2-1-96

28b. Time of  
Injury

1:30 PM

28c. Injury at  
Work?1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

STAIRS

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

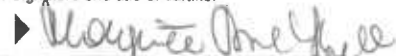
HOME

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

4047 CHAPEL RD HARFORD MD

29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier



29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

FEBRUARY 2, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wayne D. Korsch 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

FEB 5 1996

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural" or items 23c or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

1. The first part of the report is a general introduction to the subject.

2. The second part of the report is a detailed description of the methods used.

3. The third part of the report is a discussion of the results obtained.

4. The fourth part of the report is a conclusion and summary of the findings.

5. The fifth part of the report is a list of references.

6. The sixth part of the report is a list of figures and tables.

7. The seventh part of the report is a list of appendices.

8. The eighth part of the report is a list of acknowledgments.

9. The ninth part of the report is a list of footnotes.

10. The tenth part of the report is a list of references.

11. The eleventh part of the report is a list of figures and tables.

12. The twelfth part of the report is a list of appendices.

13. The thirteenth part of the report is a list of acknowledgments.

14. The fourteenth part of the report is a list of footnotes.

15. The fifteenth part of the report is a list of references.

16. The sixteenth part of the report is a list of figures and tables.

17. The seventeenth part of the report is a list of appendices.

18. The eighteenth part of the report is a list of acknowledgments.


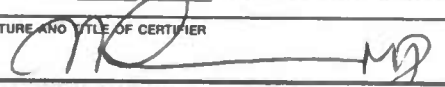
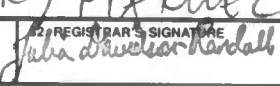


1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04894

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MARY Emma BRADFIELD</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>FEBRUARY</b> DAY <b>2</b> YEAR <b>1996</b>   |  | 3. TIME OF DEATH<br><b>745 A M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>213-18-0245</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>87</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>09-08-1908</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>CITIZENS NURSING HOME</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>HAVRE DE GRACE</b>  |  | 9c. COUNTY OF DEATH<br><b>HARFORD</b>   |  |
| 10a. STATE<br><b>MD</b>  |  |  |  | 10b. COUNTY<br><b>Harford</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Havre de Grace</b>  |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |   |  |   |  |
| 10e. STREET AND NUMBER<br><b>3628 Level Village Road</b>   |  |  |  | 10f. ZIP CODE<br><b>21078</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                         |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+) <b></b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Store Keeper</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Retail</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William Lorenza Foard</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Avarilla Cooper</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mrs. Bessie F. Gilbert</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3704 Rock Run Road, Havre de Grace, MD 21078</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>R. A. Ferris &amp; Co., Inc 2/5</b>  |  | 20c. LOCATION — City or Town, State<br><b>West Chester, PA</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Mitchell-Smith Funeral Home, P.A.<br/>123 S. Washington St. Havre de Grace, MD</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  | <p><b>a. Heart problem &amp; H. Agonal</b></p> <p><b>b. H. of Cerebrovascular Accident</b></p> <p><b>c. SILENT the Insulin</b></p> <p><b>d. H. of HXCP/Compensatory Head Failure</b></p>   |  |   |  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>H. of Rectal &amp; G. of P. Kidney</b>  |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |   |  |   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>NA</b>   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                    |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><br><b>MD</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D19583</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>2/2/96</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>CAZATY MAXWELL MD 8 Low St. Abingdon, MD 2001</b>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 5 1996</b>   |  | 32. REGISTRAR'S SIGNATURE<br>   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

68760

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR   |  |   |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 96 04895   |  |   |  |
|--|--|---|--|---|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)   |  |   |  | 2. DATE OF DEATH  |  |   |  | 3. TIME OF DEATH   |  |   |  |
| CARRIE Mae BUCKLER   |  |   |  | FEBRUARY 6, 1996  |  |   |  | 5:55 A.M.  |  |   |  |
| 4. SOCIAL SECURITY NUMBER  |  | 5. SEX  |  | 6. AGE (In yrs. last birthday)  |  | 7. DATE OF BIRTH  |  | 8. BIRTHPLACE (State or Foreign Country)                                     |  |   |  |
| 213-44-4627  |  | 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F    |  | 81 YRS.   |  | Sep 7, 1914   |  | Maryland   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH   |  |   |  | 9c. COUNTY OF DEATH  |  |   |  |
| UNIVERSITY OF Maryland   |  |   |  | BALTIMORE   |  |   |  |  |  |   |  |
| RESIDENCE OF DECEDENT  |  |   |  |   |  |   |  |  |  |   |  |
| 10a. STATE   |  | 10b. COUNTY   |  | 10c. CITY, TOWN OR LOCATION   |  | 10d. INSIDE CITY LIMITS?  |  |  |  |   |  |
| Maryland   |  | St. Mary's  |  | Mechanicsville  |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |  |  |   |  |
| 10a. STREET AND NUMBER   |  |   |  | 10f. ZIP CODE   |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?  |  |   |  |
| 3785 Mechanicsville Chaptico Road  |  |   |  | 20659   |  |   |  | U.S.A.   |  |   |  |
| 11. MARITAL STATUS   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?                             |  | 13. WAS DECEDENT OF HISPANIC ORIGIN?  |  | 14. RACE — American Indian, Black, White, etc.                          |  |  |  |   |  |
| 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married   |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | Specify: White  |  |  |  |   |  |
| 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | IF YES, GIVE WAR OR DATES   |  | Specify:  |  |   |  |  |  |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)  |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)  |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |   |  |
| Elementary/Secondary (0-12) College (1-4 or 5+)  |  |   |  | Homemaker   |  |   |  | Own Home   |  |   |  |
| 8th Grade  |  |   |  |   |  |   |  |  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)   |  |   |  |  |  |   |  |
| John Walter Tippet   |  |   |  | Lala Morgan   |  |   |  |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)   |  |   |  |  |  |   |  |
| Elmer Francis Buckler, Sr.   |  |   |  | 3785 Mechanicsville Chaptico Rd., Mechanicsville MD 20659   |  |   |  |  |  |   |  |
| 20a. METHOD OF DISPOSITION   |  |   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)   |  |   |  | 20c. LOCATION — City or Town, State  |  |   |  |
| 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State  |  |   |  | Trinity Memorial Gardens 2/9/96   |  |   |  | Waldorf, Maryland  |  |   |  |
| 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |   |  |   |  |   |  |  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  |  |   |  | 22. NAME AND ADDRESS OF FACILITY  |  |   |  |  |  |   |  |
| Michael L. Gardiner  |  |   |  | Mattingley-Gardiner Funeral Home, P.A.<br>P.O. Box 270, Leonardtown, Maryland 20650   |  |   |  |  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |   |  |   |  | Approximate Interval Between Onset and Death                                 |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  |   |  |   |  |   |  | 6 DAYS   |  |   |  |
| a. GI BLEED  |  |   |  |   |  |   |  |  |  |   |  |
| b. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |   |  |  |  |   |  |
| c. BASTRIC ULCERS  |  |   |  |   |  |   |  |  |  |   |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |   |  |  |  |   |  |
| Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST   |  |   |  |   |  |   |  |  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |  |
| MYOCARDIAL INFARCTION  |  |   |  |   |  |   |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO      |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO     |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>  |  |   |  |   |  |   |  |  |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?   |  |   |  | 26. PLACE OF DEATH (Check only one)   |  |   |  |  |  |   |  |
| 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |   |  | 1 <input checked="" type="checkbox"/> Hospital: 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |   |  |
| 27. MANNER OF DEATH  |  |   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY   |  | 28c. INJURY AT WORK?   |  | 28d. DESCRIBE NOW INJURY OCCURRED   |  |
| 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |  |   |  |   |  | M   |  | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                 |  |   |  |
|  |  |   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |  |   |  |
|  |  |   |  |   |  |   |  |  |  |   |  |
| 29a. CERTIFIER (Check only one)  |  |   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER   |  |   |  |  |  |   |  |
| 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  | PO 9727   |  |   |  |  |  |   |  |
| 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  | February 7, 1996  |  |   |  |  |  |   |  |
|  |  |   |  | 29c. LICENSE NUMBER   |  |   |  | 29d. DATE SIGNED (Month, Day, Year)  |  |   |  |
|  |  |   |  |   |  |   |  |  |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  |  |   |  |   |  |   |  |  |  |   |  |
| LEIGH EBONY BOULWARE 22 South Green St. BALT. Md. 21201  |  |   |  |   |  |   |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)  |  |   |  | 32. REGISTRAR'S SIGNATURE   |  |   |  |  |  |   |  |
| FEB - 9 1996   |  |   |  | John Davidson-Randall   |  |   |  |  |  |   |  |

001: 11 3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04896

|  |   |  |   |                                      |  |   |   |   |  |                            |  |  |  |  |  |  |                                  |  |  |  |  |  |  |   |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |
|--|---|--|---|--------------------------------------|--|---|---|---|--|----------------------------|--|--|--|--|--|--|----------------------------------|--|--|--|--|--|--|---|-------------------------------------|--|--|--|--|--|--|-------------------------------------|--|--|--|--|--|--|-------------------------------------|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>RANDOLPH STEVEN BRENT</b>  |  |   |                                      | 2. Date of Death<br>Month <b>02</b> Day <b>02</b> Year <b>96</b>   |   | 3. Time of Death<br><b>6:10 Am</b>                                      |   |  |                            |  |  |  |  |  |  |                                  |  |  |  |  |  |  |   |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>8915 Crandall Road</b>   |  |   |                                      | 4b. City, Town, or Location of Death<br><b>Lanham</b>  |   | 4c. County of Death<br><b>Prince George's</b>                           |   |  |                            |  |  |  |  |  |  |                                  |  |  |  |  |  |  |   |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>220-02-7996</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |                                      | 7. Age (In yrs. last birthday)<br><b>28</b> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><b>5-20-67</b>                   |   |  |                            |  |  |  |  |  |  |                                  |  |  |  |  |  |  |   |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Washington, DC</b>   |  | 10a. State<br><b>Maryland</b>   |                                      | 10b. County<br><b>Prince George's</b>  |   | 10c. City, Town or Location<br><b>Lanham</b>                            |   |  |                            |  |  |  |  |  |  |                                  |  |  |  |  |  |  |   |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>8915 Crandall Road</b>   |                                      | 10f. Zip Code<br><b>20706</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>                             |   |  |                            |  |  |  |  |  |  |                                  |  |  |  |  |  |  |   |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |
|  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                      | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b> |   |  |                            |  |  |  |  |  |  |                                  |  |  |  |  |  |  |   |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4or 5+) <input checked="" type="checkbox"/> <b>1+</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Computer Operator</b>             |                                      | 16b. Kind of Business/Industry<br><b>Private</b>   |   |   |   |  |                            |  |  |  |  |  |  |                                  |  |  |  |  |  |  |   |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>James Brent</b>   |  |   |                                      | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ethel Sykes</b>  |   |   |   |  |                            |  |  |  |  |  |  |                                  |  |  |  |  |  |  |   |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Ethel Marie Brent/Mother</b>   |  |   |                                      | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8915 Crandall Road, Lanham, MD 20706</b>   |   |   |   |  |                            |  |  |  |  |  |  |                                  |  |  |  |  |  |  |   |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Harmony Memorial Pk</b>  |                                      | Date<br><b>2/6</b>   |   | 20c. Location - City or Town, State<br><b>Landover, MD</b>              |   |  |                            |  |  |  |  |  |  |                                  |  |  |  |  |  |  |   |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Juanana L. Braxton</b>  |  |   |                                      | 22. Name and Address of Facility<br><b>J. B. Jenkins Funeral Home<br/>7474 Landover Road, Landover, MD 20785</b>   |   |   |   |  |                            |  |  |  |  |  |  |                                  |  |  |  |  |  |  |   |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |                                      |  |   |   |   |  |                            |  |  |  |  |  |  |                                  |  |  |  |  |  |  |   |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |
|  | <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td colspan="7">e. <b>Seizure disorder</b></td> </tr> <tr> <td colspan="7">Due to (or as a consequence of):</td> </tr> <tr> <td rowspan="2">Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</td> <td colspan="7">b. Due to (or as a consequence of):</td> </tr> <tr> <td colspan="7">c. Due to (or as a consequence of):</td> </tr> <tr> <td colspan="7">d. Due to (or as a consequence of):</td> </tr> </table> |  |   |                                      |  |   |   |   | Immediate Cause (Final disease or condition resulting in death)  | e. <b>Seizure disorder</b> |  |  |  |  |  |  | Due to (or as a consequence of): |  |  |  |  |  |  | Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): |  |  |  |  |  |  | c. Due to (or as a consequence of): |  |  |  |  |  |  | d. Due to (or as a consequence of): |  |  |  |  |  |  |
|  | Immediate Cause (Final disease or condition resulting in death)   | e. <b>Seizure disorder</b>   |   |                                      |  |   |   |   |  |                            |  |  |  |  |  |  |                                  |  |  |  |  |  |  |   |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |
| Due to (or as a consequence of):   |   |  |   |                                      |  |   |   |   |  |                            |  |  |  |  |  |  |                                  |  |  |  |  |  |  |   |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |
| Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  |   | b. Due to (or as a consequence of):  |   |                                      |  |   |   |   |  |                            |  |  |  |  |  |  |                                  |  |  |  |  |  |  |   |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |
|  |   | c. Due to (or as a consequence of):  |   |                                      |  |   |   |   |  |                            |  |  |  |  |  |  |                                  |  |  |  |  |  |  |   |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |
| d. Due to (or as a consequence of):  |   |  |   |                                      |  |   |   |   |  |                            |  |  |  |  |  |  |                                  |  |  |  |  |  |  |   |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |   |  |   |                                      |  |   |   |   |  |                            |  |  |  |  |  |  |                                  |  |  |  |  |  |  |   |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |
| <table border="1"> <tr> <td>24a. Was an autopsy performed?<br/><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</td> <td colspan="7">24b. Were autopsy findings available prior to completion of cause of death?<br/><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</td> </tr> </table>  |   |  |   |                                      |  |   |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                            |  |  |  |  |  |  |                                  |  |  |  |  |  |  |   |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |                                      |  |   |   |   |  |                            |  |  |  |  |  |  |                                  |  |  |  |  |  |  |   |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |   |                                      |  |   |   |   |  |                            |  |  |  |  |  |  |                                  |  |  |  |  |  |  |   |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |   |  |   |                                      |  |   |   |   |  |                            |  |  |  |  |  |  |                                  |  |  |  |  |  |  |   |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)                                       |   | 28b. Time of Injury<br><b>M</b>      |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   | 28d. Describe how injury occurred   |  |                            |  |  |  |  |  |  |                                  |  |  |  |  |  |  |   |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |   |                                      |  |   |   |   |  |                            |  |  |  |  |  |  |                                  |  |  |  |  |  |  |   |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |   |                                      |  |   |   |   |  |                            |  |  |  |  |  |  |                                  |  |  |  |  |  |  |   |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |
| 29b. Signature and title of certifier<br><b>[Signature]</b>  |   |  |   | 29c. License number<br><b>034732</b> |  | 29d. Date signed (Month, Day, Year)<br><b>2-2-96</b>  |   |   |  |                            |  |  |  |  |  |  |                                  |  |  |  |  |  |  |   |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Vicken K. Pouchikian 5632 Annapolis Rd #3 Bladensburg MD 20710</b>  |   |  |   |                                      |  |   |   |   |  |                            |  |  |  |  |  |  |                                  |  |  |  |  |  |  |   |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 07 1996</b>  |   | 32. Registrar's Signature<br><b>[Signature]</b>                              |   |                                      |  |   |   |   |  |                            |  |  |  |  |  |  |                                  |  |  |  |  |  |  |   |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

800.00

LEB 01 1986

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04897

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ROXANNE YVETTE BYNUM

2. Date of Death  
Month Day Year

February 2, 1996

3. Time of Death

4:00 Am

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

3241 Walters Lane #101

4b. City, Town, or Location of Death

Forestville, MD.

4c. County of Death

PRINCE GEORGE'S

5. Social Security Number

578-84-4174

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

34

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Aug 28, 1961

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10e. State

Maryland

10b. County

Prince Georges

10c. City, Town or Location

Forestville, Maryland

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

3241 Walters Lane #101

10f. Zip Code

20747

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Navar Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
116e. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Legal Secretary

16b. Kind of Business/Industry

EEDC Federal Gov't

17. Father's Name (First, Middle, Last)

Phillip H. Stancil

18. Mother's Name (First, Middle, Maiden Surname)

Yvonne C. Tillman

19a. Informant's Name/Relationship (Type, Print)

Yvonne C. Prince/Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5580 Auras Place Ft. Washington, MD. 20744

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Harmony Memorial Park

Data

2-8-96

20c. Location - City or Town, State

Landover, Maryland

21. Signature of Funeral Service Licensee

Alexander S. Pope

22. Name and Address of Facility

Alexander S. Pope Funeral Homes

5538 Marlboro Pike Forestville, MD. 20747

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final  
disease or condition  
resulting in death)

a. Myocardial Infarction

Due to (or as a consequence of):

minutes

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Diabetes Mellitus

Due to (or as a consequence of):

years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Morbid Obesity

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident  
3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28e. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only one)1 ☐ Certifying Physician2 ☒ Medical ExaminerTo the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

J. Berger MD

29c. License number

D 25925

29d. Date signed (Month, Day, Year)

February 2, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. BERGER MD #205 7720 Wisconsin Ave, Bethesda, Md. 20814.

31. Date filed (Month, Day, Year)

FEB 07 1996

32. Registrar's Signature

Julia Anderson-Robert

State  
Registrar

Baltimore, Maryland 21215-0020

10 1/9

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Page 1

The first of these is the fact that the population of the United States is increasing at a rapid rate.

It is estimated that by the year 2000, the population of the United States will be approximately 250 million.

This increase in population has led to a corresponding increase in the demand for food and other necessities.

One of the main reasons for this increase in demand is the fact that the average American consumes more food than ever before.

For example, the average American consumes about 150 pounds of meat per year, compared to about 100 pounds in 1900.

This increase in consumption has led to a corresponding increase in the demand for land to raise the food.

It is estimated that by the year 2000, the United States will need about 1 billion acres of land to produce the food it needs.

This is a significant increase from the 500 million acres that the United States has at present.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR  |  |   |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO.  |  | 96 04898  |  |
|---|--|---|--|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Andrice Marie Bell</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH <b>02</b> DAY <b>05</b> YEAR <b>96</b>  |  |   |  | 3. TIME OF DEATH<br><b>7:50 A. M.</b>   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>066-46-1022</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>40</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>09/26/55</b>                                      |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Glen Cove, N.Y.</b>                                    |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Allegis Health &amp; Rehab. Center</b>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Clinton</b>   |  |   |  | 9c. COUNTY OF DEATH<br><b>P.G.</b>  |  |   |  |
| 10a. STATE<br><b>MD</b>   |  | 10b. COUNTY<br><b>P.G.</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Fort Washington</b>   |  |   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO       |  |   |  |
| 10e. STREET AND NUMBER<br><b>3720 Lumar Dr.</b>   |  |   |  | 10f. ZIP CODE<br><b>20744</b>   |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Black</b>                            |  |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>None</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>None</b>   |  |   |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Bronson Bell Jr.</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Pearl Richardson</b>  |  |   |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Pearl Bell &amp; Phyllis Meekins</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3720 Lumar Dr. Ft. Washington, Md. 20744</b>  |  |   |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Harmony Cemetery 2/10/96</b>  |  | 20c. LOCATION — City or Town, State<br><b>Landover, MD.</b>   |  |   |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>James Edwards</i>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Hodges and Edwards<br/>3910 Silver Hill RD. Suitland, Md.</b>  |  |   |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>AIDS</u></b><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |   |  |   |  |   |  | Approximate Interval Between Onset and Death<br><b>3 years.</b>                                       |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>  |  |   |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>S. Tallawi</i><br><b>S. TALLAWI, MD.</b>  |  |   |  | 29c. LICENSE NUMBER<br><b>D34274</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>2/5/96</b>  |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>S. TALLAWI, MD. 7700 Old Branch Ave, Clinton, Md.</b>   |  |   |  | 31. DATE FILED (Month, Day, Year)<br><b>FEB 07 1996</b>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>John Anderson</i>   |  |   |  |

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR   |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  | 96 04899   |  |
|--|--|--|--|--|--|
|  |  | CERTIFICATE OF DEATH   |  | REG. NO.   |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br>SARAH KATHERINE BUSCHER  |  | 2. DATE OF DEATH<br>MONTH January DAY 26, YEAR 1996  |  | 3. TIME OF DEATH<br>7:25 A M   |  |
| 4. SOCIAL SECURITY NUMBER<br>579-20-1003   | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday)<br>77 YRS.  | 7. DATE OF BIRTH (Month, Day, Year)<br>July 11, 1918 | 8. BIRTHPLACE (State or Foreign Country)<br>Washington, DC   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Allegis Nursing Home   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Clinton   |  | 9c. COUNTY OF DEATH<br>Prince George's   |  |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Calvert   |  | 10c. CITY, TOWN OR LOCATION<br>Huntingtown   |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br>2002 Smoky Road  |  | 10f. ZIP CODE<br>20639   |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White   |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (9-12) 12 College (1-4 or 5+) 12   |  |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Homemaker  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Own Home   |  | 17. FATHER'S NAME (First, Middle, Last)<br>Stephen Beach   |  |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Elizabeth Hamilton  |  | 19a. INFORMANT'S NAME (Type/Print)<br>Stephen R. Buscher   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2002 Smoky Road, Huntingtown, Maryland 20639  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Fort Lincoln Cemetery 02/01/96  |  | 20c. LOCATION — City or Town, State<br>Brentwood, Maryland   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Henry S. Paul</i>  |  | 22. NAME AND ADDRESS OF FACILITY<br>Francis Gasch's Sons Funeral Home, P.A.<br>4739 Baltimore Ave., Hyattsville, MD 20781  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</i><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b.<br>c.<br>d.<br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Diabetic mellitus</i> |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 25. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |
| 26. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  |
| 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Dr. Frank Ryan</i>   |  | 29c. LICENSE NUMBER<br>D19481  |  |
| 29d. DATE SIGNED (Month, Day, Year)<br>1/30/96   |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Dr. Frank Ryan 6188 Oxon Hill Road, Oxon Hill, Maryland 20745-3113  |  | 31. DATE FILED (Month, Day, Year)<br>FEB 05 1996   |  |
| 32. REGISTRAR'S SIGNATURE<br><i>John A. Anderson-Randall</i>   |  |  |  |  |  |

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

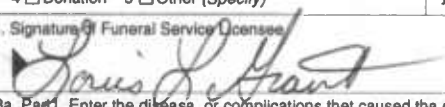

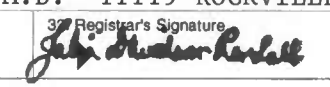
| 1. FOR STATE REGISTRAR   |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |   | 96 04900  |  |
|--|--|---|--|--|---|---|--|
|  |  | CERTIFICATE OF DEATH  |  |  |   | REG. NO.  |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>EDNA M. BAILEY</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>JANUARY</b> DAY <b>26</b> YEAR <b>1996</b>  |   | 3. TIME OF DEATH<br><b>11:25 P.M.</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>212-01-3933</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 6. AGE (In yrs. last birthday)<br><b>94</b> YRS. | 7. DATE OF BIRTH (Month, Day, Year)<br><b>MAY 8, 1901</b>  | 8. BIRTHPLACE (State or Foreign Country)<br><b>MARYLAND</b> |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>NATIONAL LUTHERAN HOME</b>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>ROCKVILLE</b>  |   | 9c. COUNTY OF DEATH<br><b>MONTGOMERY CO.</b>  |  |
| 10a. STATE<br><b>MD.</b>   |  |   |  | 10b. COUNTY<br><b>HARFORD CO.</b>  |   | 10c. CITY, TOWN OR LOCATION<br><b>BEL AIR</b>   |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |   |  | 10e. STREET AND NUMBER<br><b>410- McPHAIL ROAD</b>   |   | 10f. ZIP CODE<br><b>21014</b>   |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |   |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |   | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |   | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>SECRETARY</b> |  |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>SECRETARY</b>   |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>NOT AVAILABLE</b>   |   |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>BENJAMIN FREDERICK HALLMAN</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>CAROLINE PAUL</b>  |   |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>REV. DR. REICHARD</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9701- VEIRS DRIVE, ROCKVILLE, MD. 20850</b>                                |   |   |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>METROPOLITAN CREMATORY-1/29-ALEXANDRIA, VA.</b>  |   | 20c. LOCATION — City or Town, State   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>W. M. Hysong</b>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>HYSONG CO., INC.<br/>1300-N STREET, NW, WASH., DC</b>   |   |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>stroke</b><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |   |  | Approximate interval Between Onset and Death<br><b>hours</b>   |   |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Alzheimer's</b>   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO       |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>  |  |   |  |  |   |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>  |   | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |   |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Daniel Jaller</b>   |  | 29c. LICENSE NUMBER<br><b>D33138</b>   |   | 29d. DATE SIGNED (Month, Day, Year)<br><b>1-27-96</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Daniel Jaller 12850 Middlebrook Dr. Germantown, MD</b>   |  | 31. DATE FILED (Month, Day, Year)<br><b>FEB 08 1996</b>   |  |  |   |   |  |
| 32. REGISTRAR'S SIGNATURE<br><b>John H. Hysong</b>   |  |   |  |  |   |   |  |

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**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

Reg. No. **96 04901**

|   |  |                                       |   |  |  |   |  |  |   |  |
|---|--|---------------------------------------|---|--|--|---|--|--|---|--|
| <b>Physician<br/>/Medical<br/>Examiner</b>  | 1. Decedent's Name (First, Middle, Last)<br><b>JAMES STEVENS BARGE, II</b>                   |                                       |   |  |  | 2. Date of Death<br>Month Day Year<br><b>January 27, 1996</b>                   |  | 3. Time of Death<br><b>7:55 pm</b>   |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>ST. MARY'S HOSPITAL</b> |                                       |   |  |  | 4b. City, Town, or Location of Death<br><b>LEONARDTOWN</b>                      |  | 4c. County of Death<br><b>ST. MARY'S</b>   |   |  |
| <b>Funeral<br/>Director</b>   | 5. Social Security Number<br><b>578-30-9542</b>  |                                       | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>69</b> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><b>SEPT. 11, 1926</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>GEORGIA</b>  |  |
|   | Usual Residence of Decedent  |                                       |   |  |  |   |  |  |   |  |
| 10a. State<br><b>MARYLAND</b>   |  | 10b. County<br><b>PRINCE GEORGE'S</b> |   | 10c. City, Town or Location<br><b>BERWYN HEIGHTS</b>   |  |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |
| 10e. Street and Number<br><b>8406 58TH AVENUE</b>   |  |                                       |   |  | 10f. Zip Code<br><b>20740</b>  |   | 10g. Citizen of What Country?<br><b>UNITED STATES</b>  |  |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  |                                       | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1945-1947</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                        |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>College</b>  |  |                                       |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>POSTAL CARRIER</b> |  |   | 16b. Kind of Business/Industry<br><b>U.S. GOVERNMENT</b>   |  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>JAMES S. BARGE, I</b>   |  |                                       |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>VELMA LOUISE CARTER</b> |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>SHERIE LOUISE BARGE, DAUGHTER</b>  |  |                                       |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>42 KELLY LANE, NEWNAN, GEORGIA 30265</b>   |   |  |  |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |                                       | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>FORT LINCOLN CEMETERY</b>  |  |  | Date<br><b>2/9/96</b>   |  | 20c. Location - City or Town, State<br><b>BRENTWOOD, MARYLAND</b>                              |   |  |
| 21. Signature of Funeral Service Licensee<br>   |  |                                       |   |  | 22. Name and Address of Facility<br><b>FORT LINCOLN FUNERAL HOME, INC.<br/>3401 BLADENSBURG RD., BRENTWOOD, MD 20722</b>   |   |  |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |                                       |   |  |  |   |  |  | Approximate Interval Between Onset and Death  |  |
| <div style="display: flex; align-items: center;"> <div style="margin-right: 10px;">                 Immediate Cause (Final disease or condition resulting in death)<br/><br/>                 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last             </div> <div style="border-left: 2px solid black; padding-left: 10px;">                 a. <b>SEPSIS</b><br/>Due to (or as a consequence of):<br/>                 b. <b>PNEUMONIA</b><br/>Due to (or as a consequence of):<br/>                 c. <b>CONGESTIVE HEART FAILURE</b><br/>Due to (or as a consequence of):<br/>                 d.             </div> <div style="margin-left: 10px; text-align: center;">                 T Wk<br/>                 4 Wk<br/>                 6 months             </div> </div> |  |                                       |   |  |  |   |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |                                       |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |   |  |
|   |  |                                       |   |  |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |                                       | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  |                                       | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  |
|   |  |                                       | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> <b>Certifying Physician:</b> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> <b>Medical Examiner:</b> On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |                                       |   |  |  |   |  |  |   |  |
| 29b. Signature and title of certifier<br> M.D.   |  |                                       |   |  | 29c. License number<br><b>D46246</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>1/27/1996</b>  |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ASHRAF M. MEELU, M.D. 11119 ROCKVILLE PIKE ROCKVILLE, MARYLAND 20852</b>   |  |                                       |   |  |  |   |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 08 1996</b>   |  |                                       | 32. Registrar's Signature<br>  |  |  |   |  |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

10296 86



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04902

|  |  |  |  |   |  |   |  |   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Willie M. Brydie</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JAN 25 96</b>  |  | 3. TIME OF DEATH<br>HOUR MIN AM/PM<br><b>6:30 A M</b>   |  |   |  |   |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>228-36-1611</b>  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>63</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>9 30-32 VIRGINIA</b>                                      |  |   |  |   |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>13017 Chalfont Ave.</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>FT. WASH., MD.</b>  |  | 9c. COUNTY OF DEATH<br><b>P. G.</b>   |  |   |  |   |  |  |  |
| 10a. STATE<br><b>MD</b>  |  | 10b. COUNTY<br><b>P. G.</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>FT. WASHINGTON</b>  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |   |  |   |  |  |  |
| 10e. STREET AND NUMBER<br><b>13017 Chalfont Ave</b>  |  |  |  | 10f. ZIP CODE<br><b>20744</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   |  |   |  |  |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>                             |  |   |  |   |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7th</b> College (1-4 or 5+)   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>LABORER</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Construction</b>   |  |   |  |   |  |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Thomas Brydie</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Lillian Foy</b>   |  |   |  |   |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Thomas Brydie</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>13017 Chalfont Ave. MD. 20744</b>   |  |   |  |   |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>METROPOLITAN CREMATORY 1/31/96</b>   |  | 20c. LOCATION — City or Town, State<br><b>ALEX., VA.</b>  |  |   |  |   |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Clinton Layton</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>ROBERT G. MASON FUNERAL HOME<br/>1661 Goodhope Rd. S.E. WASH. 20020</b>  |  |   |  |   |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Hypertensive Cardiovascular Disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |   |  | Approximate Interval Between Onset and Death  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Leg Amputee, Stuttered '91-'93</b>  |  |  |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |  |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  |   |  |   |  |   |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |   |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO     |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |  |  |
|  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                        |  |   |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Augusto P. Rodriguez MD. H 21230</b>                          |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>January 25, 96</b> |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type/Print)<br><b>Augusto P. Rodriguez MD. 5009 Rayburn Ct. Conit. Springs, MD 20745</b>  |  |  |  |   |  |   |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 08 1996</b>  |  | 32. REGISTRAR'S SIGNATURE<br><b>John Andrew Randall</b>  |  |   |  |   |  |   |  |   |  |  |  |

200.00 a

200.00 a

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |   |   |  |   |  |   | 96 04903 |
|--|--|--|---|---|---|--|---|--|---|----------|
| 1. DECEASED'S NAME (First, Middle, Last)   |  | 2. DATE OF DEATH   |   |   |   | 3. TIME OF DEATH   |   |  |   |          |
| BEATRICE J BEUZARD   |  | FEB 5 1996   |   |   |   | 11:51 P M  |   |  |   |          |
| 4. SOCIAL SECURITY NUMBER<br>220-24-6957   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br>69 YRS. | 7. DATE OF BIRTH (Month, Day, Year)<br>10-23-26   |   | 8. BIRTHPLACE (State or Foreign Country)<br>Virginia                                 |   |  |   |          |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Mercy Hospital   |  |  |   | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore  |   |  | 9c. COUNTY OF DEATH<br>Baltimore  |  |   |          |
| RESIDENCE OF DECEASED  |  |  |   |   |   |  |   |  |   |          |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Prince George's   |   | 10c. CITY, TOWN OR LOCATION<br>Landover   |   |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |   |          |
| 10e. STREET AND NUMBER<br>6711 Camden Street   |  |  |   | 10f. ZIP CODE<br>20785  |   | 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |   |  |   |          |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |   | 13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: Black                                    |  |   |          |
| 15. DECEASED'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>11th   |  | 15b. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Homemaker  |   | 16. KIND OF BUSINESS/INDUSTRY<br>Private  |   |  |   |  |   |          |
| 17. FATHER'S NAME (First, Middle, Last)<br>William Clark   |  |  |   |   | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Martha Miles   |  |   |  |   |          |
| 19a. INFORMANT'S NAME (Type/Print)<br>Juanita Washington/Sister  |  |  |   |   | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>6711 Camden Street, Landover, MD 20785 |  |   |  |   |          |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Arlington National Cem 2/12   |   |   | 20c. LOCATION — City or Town, State<br>Arlington, Virginia  |  |   |  |   |          |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Kimberly Buscoe-Tonic   |  |  |   |   | 22. NAME AND ADDRESS OF FACILITY<br>J. B. Jenkins Funeral Home<br>7474 Landover Rd, Landover, MD 20785                                  |  |   |  |   |          |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>a. Acute myocardial infarction suspected<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. Atherosclerotic heart disease<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. Hypertension<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. Congestive heart failure |  |  |   |   |   |  |   |  | Approximate Interval Between Onset and Death<br>30 minutes<br>10 hrs<br>10 hrs<br>4 hrs                   |          |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Multiple sclerosis respiratory failure<br>ventilator dependency  |  |  |   |   |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |          |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |   |   |   |  |   |  |   |          |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |   |   |   |  |   |  |   |          |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |   |  |   |  |   |          |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |   | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |   | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |  |   |          |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |   | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |   |  |   | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |   |          |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |   |   |   |  |   |  |   |          |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  |  |  |   | 29c. LICENSE NUMBER<br>D36494   |   | 29d. DATE SIGNED (Month, Day, Year)<br>2/6/1996                                      |   |  |   |          |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>K. DESHAI MD 4660 Wilkens Ave Baltimore MD 21229  |  |  |   |   |   |  |   |  |   |          |
| 31. DATE FILED (Month, Day, Year)<br>FEB 09 1996   |  | 32. REGISTRAR'S SIGNATURE<br>John Andrew Radloff   |   |   |   |  |   |  |   |          |

2110

2110 2110 2110

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04904

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

TAMIKA DENISE BLACK

2. Date of Death

JAN. 27, 1996

3. Time of Death

0825 AM

4a. Facility Name (If not institution, give street and number)

RT.#197 &amp; LOBOLLY PINE DRIVE

4b. City, Town, or Location of Death

BOWIE

4c. County of Death

PRINCE GEORGES

Funeral  
Director

5. Social Security Number

579-96-0541

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

19

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 23, 1976

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

District of Columbia

10b. County

10c. City, Town or Location

Washington

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

100 Tuckerman Street, N. W.

10f. Zip Code

20011

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1 year

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Nurse School Teacher

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

Darrell Wayne

Black

18. Mother's Name (First, Middle, Maiden Surname)

Joyce Elvira

Gaston

19a. Informant's Name/Relationship (Type, Print)

Darrell W. Black (father)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

710 King Lane, Fort Washington, Maryland 20744

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Washington National Cemetery

20c. Location - City or Town, State

Suitland, Maryland

21. Signature of Funeral Service Licensee

Latney's Funeral Home

22. Name and Address of Facility

3831 Georgia Avenue, N.W.; Washington, D.C. 20011

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

e. GUNSHOT WOUNDS, CHEST AND BACK

Due to (or as a consequence of):

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

ROADWAY

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☒ Homicide

28a. Date of Injury

1/27/1996

28b. Time of Injury

FOUR 0358 AM

28c. Injury et Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

SUBJECT WAS SHOT

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

ROADWAY

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)PRINCE GEORGES  
ROUTE #197-BOWIE, MARYLAND29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Donald G. Wright M.D.

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

JANUARY 27, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Donald G. Wright M.D. 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

FEB 09 1996

32. Registrar's Signature

John H. Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04905

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Frances Joanne Beall

2. Date of Death

Month Day Year  
Feb. 4 1996

3. Time of Death

11:00 A.M.

4a. Facility Name (If not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

215 78 5469

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

51 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
April 9, 1944

9. Birthplace (State or Foreign Country)

Washington D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Arnold

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

47 Church Rd.

10f. Zip Code

21012

10g. Citizen of What Country?

United States

11. Marital Status

☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
1

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

N/A

18b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

Francis J. Beall

18. Mother's Name (First, Middle, Maiden Surname)

Mildred E. Ryan

19a. Informant's Name/Relationship (Type, Print)

Mildred E. Beall

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2043 Hermitage Hills Dr. Gambrills Maryland 21054

20a. Method of Disposition

☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Holy Trinity Cemetery 2/8/96

Date

20c. Location - City or Town, State

Bowie Maryland

21. Signature of Funeral Service Licensee

Robert E. Evans Pres.

22. Name and Address of Facility

Robert E. Evans Funeral Home, P.A.

16000 Annapolis Rd. Bowie Maryland 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. septic shock  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. pneumococcal pneumonia  
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

4 weeks

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Robert T. Peterson

29c. License number

D24804

29d. Date signed (Month, Day, Year)

2/6/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROBERT T. PETERSON 600 Ridgely Ave. Ste. 121 ANNAPOLIS, MD. 21401

31. Date filed (Month, Day, Year)

FEB 09 1996

32. Registrar's Signature

John A. Ruckel

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

2047

FEB 03 1988  
Philadelphia



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04906

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Pauline Maria Bell

2. Date of Death

February 3, 1996

3. Time of Death

10:15 PM

4a. Facility Name (If not institution, give street and number)

Villa Rosa Nursing Home

4b. City, Town, or Location of Death

Mitchellville

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

579 18 9448

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

93 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

August 2, 1902

9. Birthplace (State or Foreign Country)

Austria

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Bowie

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

12522 Kensington Lane

10f. Zip Code

20715

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Clerk

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

August Kienast

18. Mother's Name (First, Middle, Maiden Surname)

Maria Spindler

19a. Informant's Name/Relationship (Type, Print)

George F. Norris Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11117 Mitscher Street Kensington Md. 20895

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory 2-4-96

Date

20c. Location - City or Town, State

Alexandria Virginia

21. Signature of Funeral Service Licensee

Robert E. Evans, Pres

22. Name and Address of Facility

Robert E. Evans Funeral Home, P.A.

16000 Annapolis Rd. Bowie Maryland 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Stroke

Due to (or as a consequence of):

b.

Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

weeks

yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Colon Cancer

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Robert E. Evans MD

29c. License number

D32261

29d. Date signed (Month, Day, Year)

2-5-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William F. Felman 9500 Annapolis Rd Landover MD

31. Date filed (Month, Day, Year)

FEB 09 1996

32. Registrar's Signature

John A. Harkins

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 902-902.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1947 10 17

593 - 8500

96 04907

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |   |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>ANNA LOVING BROWN   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>JAN. 31, 1996   |  | 3. TIME OF DEATH<br>2:50 A M  |   |
| 4. SOCIAL SECURITY NUMBER<br>578-03-6331  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>94 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>Jan. 26, 1902   |   |
| 8. BIRTHPLACE (State or Foreign Country)<br>Virginia  |  | 9a. FACILITY NAME (If not Institution, give street and number)<br>MANOR CARE NURSING HOME  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>SILVER SPRING  |  | 9c. COUNTY OF DEATH<br>MONT.  |   |
| 10a. STATE  |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br>Washington, D.C.   |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br>200 4th Street S. E.  |  |  |  | 10f. ZIP CODE<br>20003  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                                    |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12<br>College (1-4 or 5+) College (1-4 or 5+)   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Hairdresser   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Beauty Shop   |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>Edward Fishel  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Mary Keller  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>Edward Loving   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>9272 Cherry Lane Laurel, MD 20708  |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Cedar Hill Cemetery 2/3   |  | 20c. LOCATION — City or Town, State<br>Suitland, MD   |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Keino Simmons</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>JOS GAWLERS SONS INC.<br>5130 WI AVE N.W. WASHINGTON, D.C. 20016  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → CONGESTIVE HEART FAILURE<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequently ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |   | Approximate Interval Between Onset and Death<br>6 YEARS   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |   |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                        |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Charles M. Benner M.D.</i>  |  |  |  | 29c. LICENSE NUMBER<br>D31563   |  | 29d. DATE SIGNED (Month, Day, Year)<br>JAN 31, 1996   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Charles M. Benner, M. D. 11251 Lockwood Drive Silver Spring, MD 20901  |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br>FEB 09 1996  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Andrew Randall</i>  |  |   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Page 2

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR  |  |   |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 96 04908  |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|---|--|---|--|--|--|---|--|
| CERTIFICATE OF DEATH  |  |   |  | REG. NO.   |  |   |  |   |  |   |  |  |  |   |  |
| 1. DECEASED'S NAME (First, Middle, Last)<br><b>ROY A. BLEVINS</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH <b>02</b> DAY <b>08</b> YEAR <b>96</b>   |  |   |  | 3. TIME OF DEATH<br><b>10:53 P M</b>  |  |   |  |  |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>408-24-5235</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>77</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>  |  | IF UNDER 24 HRS.<br>HOURS <b></b> MIN. <b></b>  |  | 7. DATE OF BIRTH<br>Month, Day, Year<br><b>10 11 18</b> |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Tennessee</b>                               |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Holy Cross Hospital</b>  |  |   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Silver Spring</b>   |  |   |  | 9c. COUNTY OF DEATH<br><b>Montgomery</b>                |  |  |  |   |  |
| RESIDENCE OF DECEASED   |  |   |  |  |  |   |  |   |  |   |  |  |  |   |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Montgomery</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Silver Spring</b>  |  |   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |   |  |  |  |   |  |
| 10e. STREET AND NUMBER<br><b>10304 Haywood Drive</b>  |  |   |  | 10f. ZIP CODE<br><b>20901</b>  |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  |  |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEASED EVER IN U.S. ARMY FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WW II</b> |  | 13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                      |  |   |  |  |  |   |  |
| 15. DECEASED'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b></b> College (1-4 or 5+) <b>4</b>  |  | 16a. DECEASED'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Printer</b>                             |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Washington Post Newspaper</b>  |  |   |  |   |  |  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William H. Blevins</b>  |  |   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Lillian J. Campbell</b>   |  |   |  |   |  |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Patricia R. Blevins</b>  |  |   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>10304 Haywood Drive Silver Spring, Maryland 20901</b> |  |   |  |   |  |  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory 2/11/96 Alexandria, Virginia</b>               |  |  |  | DATE<br><b>2/11/96</b>  |  | 20c. LOCATION — City or Town, State<br><b>Alexandria, Virginia</b>                              |  |   |  |  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>James S. Dooley</b>   |  |   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Francis J. Collins Funeral Home, Inc.<br/>500 University Blvd., W. Sil. Spr., MD 20901</b>                         |  |   |  |   |  |  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ACUTE MYOCARDIAL INFARCTION</b><br><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br><br>d.<br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b> |  |   |  |  |  |   |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |   |  |  |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide   |  |   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  | 28d. DESCRIBE HOW INJURY OCCURRED                       |  |  |  |   |  |
|   |  |   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                    |  |   |  |  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |  |  |   |  |   |  |   |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Mark H. GIG</b>   |  |   |  |  |  | 29c. LICENSE NUMBER<br><b>D24886</b>  |  |   | 29d. DATE SIGNED (Month, Day, Year)<br><b>2/9/96</b> |   |  |  |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Mark H. GIG 9801 Georgia Avenue Silver Spring Maryland 20902</b>  |  |   |  |  |  |   |  |   |  |   |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 09 1996</b>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><b>John D. Anderson</b>   |  |   |  |   |  |   |  |  |  |   |  |



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR   |  |   |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 96 04909  |  |                                     |  |
|--|--|---|--|--|--|---|--|---|--|-------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)   |  |   |  | 2. DATE OF DEATH   |  |   |  | 3. TIME OF DEATH  |  |                                     |  |
| George W. Bennis   |  |   |  | February 7, 1996   |  |   |  | 4:05 P M  |  |                                     |  |
| 4. SOCIAL SECURITY NUMBER  |  | 5. SEX  |  | 6. AGE (In yrs. last birthday)   |  | 7. DATE OF BIRTH  |  | 8. BIRTHPLACE (State or Foreign Country)                                |  |                                     |  |
| 265-05-7972  |  | 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                              |  | 84 YRS.  |  | May 8, 1911   |  | New York  |  |                                     |  |
| 9a. FACILITY NAME (If not institution, give street and number)   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH  |  |   |  | 9c. COUNTY OF DEATH   |  |                                     |  |
| Holy Cross Hospital  |  |   |  | Silver Spring  |  |   |  | Montgomery  |  |                                     |  |
| RESIDENCE OF DECEDENT  |  |   |  |  |  |   |  |   |  |                                     |  |
| 10a. STATE   |  | 10b. COUNTY   |  | 10c. CITY, TOWN OR LOCATION  |  |   |  | 10d. INSIDE CITY LIMITS?  |  |                                     |  |
| Maryland   |  | Montgomery  |  | Silver Spring  |  |   |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |                                     |  |
| 10a. STREET AND NUMBER   |  |   |  | 10f. ZIP CODE  |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?   |  |                                     |  |
| 8715 Leonard Drive   |  |   |  | 20910  |  |   |  | USA   |  |                                     |  |
| 11. MARITAL STATUS   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN?   |  | 14. RACE — American Indian, Black, White, etc.                                    |  |   |  |                                     |  |
| 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  | Specify: White  |  |   |  |                                     |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)  |  |   |  | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)   |  |   |  | 15b. KIND OF BUSINESS/INDUSTRY  |  |                                     |  |
| Elementary/Secondary (0-12) 12 College (1-4 or 5+) College   |  |   |  | Musician   |  |   |  | Music   |  |                                     |  |
| 17. FATHER'S NAME (First, Middle, Last)  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)  |  |   |  |   |  |                                     |  |
| Frank Pistek   |  |   |  | Katherine Chapella   |  |   |  |   |  |                                     |  |
| 19a. INFORMANT'S NAME (Type/Print)   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)  |  |   |  |   |  |                                     |  |
| Sylvia M. Bennis   |  |   |  | 8715 Leonard Drive Silver Spring, Maryland 20910   |  |   |  |   |  |                                     |  |
| 20a. METHOD OF DISPOSITION   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)                   |  | DATE   |  | 20c. LOCATION — City or Town, State   |  |   |  |                                     |  |
| 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | Metropolitan Crematory  |  | 2/10/96  |  | Alexandria, Virginia  |  |   |  |                                     |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  |  |   |  | 22. NAME AND ADDRESS OF FACILITY   |  |   |  |   |  |                                     |  |
| John L. Chipak   |  |   |  | Francis J. Collins Funeral Home, Inc.<br>500 University Blvd.W. Sil. Spr. MD 20901   |  |   |  |   |  |                                     |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |  |  |   |  |   |  |                                     |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → Congestive heart failure   |  |   |  |  |  |   |  |   |  |                                     |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |  |  |   |  |   |  |                                     |  |
| Acute renal failure  |  |   |  |  |  |   |  |   |  |                                     |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |  |  |   |  |   |  |                                     |  |
| Staphylococcal sepsis  |  |   |  |  |  |   |  |   |  |                                     |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |  |  |   |  |   |  |                                     |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST   |  |   |  |  |  |   |  |   |  |                                     |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  |   |  |   |  |                                     |  |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |   |  |  |  |   |  |   |  |                                     |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |   |  |  |  |   |  |   |  |                                     |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |   |  |  |  |   |  |   |  |                                     |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |   |  | 26. PLACE OF DEATH (Check only one)  |  |   |  |   |  |                                     |  |
|  |  |   |  | HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |                                     |  |
| 27. MANNER OF DEATH  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY  |  | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED                                       |  |                                     |  |
| 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |  |   |  |  |  |   |  |   |  |                                     |  |
| 29a. CERTIFIER (Check only one)  |  |   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER  |  |   |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year) |  |
| 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  | Howard Goldberg MD   |  | 30685   |  | 2/8/96  |  |                                     |  |
| 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |  |  |   |  |   |  |                                     |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  |  |   |  |  |  |   |  |   |  |                                     |  |
| Howard Goldberg MD 112013 Veris Mill Road Wheaton MD 20906   |  |   |  |  |  |   |  |   |  |                                     |  |
| 31. DATE FILED (Month, Day, Year)  |  |   |  | 32. REGISTRAR'S SIGNATURE  |  |   |  |   |  |                                     |  |
| FEB 09 1996  |  |   |  | Julia Davidson Randall   |  |   |  |   |  |                                     |  |





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04910

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Gary Wayne Bolling

2. Date of Death

Month Day Year  
February 6, 1996

3. Time of Death

4:50pm

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

789 Quince Orchard Blvd. #13

4b. City, Town, or Location of Death

Gaithersburg

4c. County of Death

Montgomery

5. Social Security Number

228-52-6976

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

54

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

July 19, 1941

9. Birthplace (State or Foreign Country)

Pound, Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10a. Street and Number

789 Quince Orchard Blvd. Apt. #13

10f. Zip Code

20878

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Computer Systems Analyst

16b. Kind of Business/Industry

Computer

17. Father's Name (First, Middle, Last)

Conrad Bolling

18. Mother's Name (First, Middle, Maiden Surname)

Mabel Hubbard

19a. Informant's Name/Relationship (Type, Print)

George Roger Bolling

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

17300 Moss Side Lane Olney, MD 20832

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Wise Cemetery

Date

2/10/96

20c. Location - City or Town, State

Wise, Virginia

21. Signature of Funeral Service Licensee

Michael D. Gibbons

22. Name and Address of Facility

DeVol Funeral Home

10 East Deer Park Drive  
Gaithersburg, MD 20877

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Myocardial Infarction

Due to (or as a consequence of):

b. Insulin Dependent Diabetes

Due to (or as a consequence of):

c. Cardiomyopathy

Due to (or as a consequence of):

d. Congestive Heart Failure

&gt; 5yr

&gt; 5yr

&gt; 5yr

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

S. G. Rao

29c. License number

D 35792

29d. Date signed (Month, Day, Year)

February 7, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

S.G. Rao, M.D., 50 West Edmonston Avenue #504, Rockville, Maryland 20852

31. Date filed (Month, Day, Year)

FEB 08 1996

32. Registrar's Signature

John A. Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. DECEDENT'S NAME (First, Middle, Last)  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR   |  |  |  | 3. TIME OF DEATH  |  |
|---|--|--|--|--|--|--|--|---|--|
| Barbara A. Beaudoin   |  |  |  | February 3, 1996   |  |  |  | 1:45 AM   |  |
| 4. SOCIAL SECURITY NUMBER   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>63 YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)   |  | 8. BIRTHPLACE (State or Foreign Country)  |  |
| 002-26-2250   |  |  |  |  |  | Nov. 1, 1932   |  | New Hampshire   |  |
| 9a. FACILITY NAME (If not Institution, give street and number)  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH  |  |  |  | 9c. COUNTY OF DEATH   |  |
| 1024 Brice Road   |  |  |  | Rockville  |  |  |  | Montgomery  |  |
| 10a. STATE  |  |  |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION  |  | 10d. INSIDE CITY LIMITS?  |  |
| Maryland  |  |  |  | Montgomery   |  | Rockville  |  | 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER  |  |  |  | 10f. ZIP CODE  |  | 10g. CITIZEN OF WHAT COUNTRY?  |  |   |  |
| 1024 Brice Road   |  |  |  | 20852  |  | United States  |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                     |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)  |  |  |  | 15e. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)  |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |   |  |
| Elementary/Secondary (0-12) College (1-4 or 5+)   |  |  |  | Homemaker  |  | Own Home   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)  |  |  |  |   |  |
| Arthur St. Germain  |  |  |  | Mary E. Ryan   |  |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)  |  |  |  |   |  |
| Clyde S. Behanna  |  |  |  | 1024 Brice Road, Rockville, Maryland 20852   |  |  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)  |  | 20c. LOCATION — City or Town, State  |  |  |  |   |  |
|   |  | February 7, 1996<br>Montgomery Crematorium, Inc.   |  | Bethesda, Maryland   |  |  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Barbara J. Muller-Lawrence</i> M00831   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Robert A. Pumphrey Funeral Home/<br>Rockville, Inc. 300 West Montgomery<br>Avenue, Rockville, Maryland 20850-2805  |  |  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |  |  |  |  |  |  | Approximate Interval Between Onset and Death  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Glioblastoma Multiforme  |  |  |  |  |  |  |  | 9 months  |  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |  |  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  |  |  |  |  |  |  |  |   |  |
| b. DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |  |   |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |  |   |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>   |  |  |  |  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)  |  |  |  |   |  |
|   |  |  |  | HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
|   |  |  |  |  |  |  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Joseph M. Haggerty MD</i>  |  |  |  | 29c. LICENSE NUMBER<br>D32407   |  |
|   |  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br>February 5, 1996  |  |  |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Joseph M. Haggerty, M.D. 9707 Medical Center Drive, #300, Rockville, MD 20850  |  |  |  |  |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>FEB 08 1996  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>  |  |  |  |   |  |

11240 20

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 04912

Physician  
/Medical  
Examiner

Funeral  
Director

|   |  |   |  |   |   |  |  |  |   |
|---|--|---|--|---|---|--|--|--|---|
| 1. Decedent's Name (First, Middle, Last)<br>Carl John Bailey  |  |   |  |   |   | 2. Date of Death<br>Month Day Year<br>February 5, 1996 |  | 3. Time of Death<br>4:35 AM  |   |
| 4a. Facility Name (If not institution, give street and number)<br>Suburban Hospital   |  |   |  | 4b. City, Town, or Location of Death<br>Bethesda  |   | 4c. County of Death<br>Montgomery                      |  |  |   |
| 5. Social Security Number<br>465-26-2297  |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>67 Yrs.  | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br>Dec. 18, 1928   |  | 9. Birthplace (State or Foreign Country)<br>Texas  |   |
| Usual Residence of Decedent   |  |   |  |   |   |  |  |  |   |
| 10a. State<br>Maryland  |  | 10b. County<br>Montgomery   |  | 10c. City, Town or Location<br>Potomac  |   |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   |
| 10e. Street and Number<br>10729 Deborah Drive   |  |   | 10f. Zip Code<br>20854   |   |   | 10g. Citizen of What Country?<br>United States         |  |  |   |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No WW II<br>If Yes, Give Year or Dates: Korea |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12+<br>College (1-4or 5+)  |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Underwriter   |   |   | 16b. Kind of Business/Industry<br>N. F. I. P.          |  |  |   |
| 17. Father's Name (First, Middle, Last)<br>Charles Bailey   |  |   |  |   | 18. Mother's Name (First, Middle, Maiden Summa)<br>Gabina (Unavailable) |  |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br>Nancy Bailey  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>Same as 10   |   |  |  |  |   |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Chesapeake Crematory   |   | Date<br>2-6-96  |  | 20c. Location - City or Town, State<br>Beltsville, Maryland  |  |   |
| 21. Signature of Funeral Service Licensee<br>Eileen H. Rapp   |  |   |  | 22. Name and Address of Facility<br>Rapp Funeral Services, P. A.<br>933 Gist Avenue, Silver Spring, MD 20910  |   |  |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Pulmonary edema<br>Due to (or as a consequence of):<br>b. Cardiac arrhythmia<br>Due to (or as a consequence of):<br>c. Atherosclerotic heart disease<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |   |   |  |  |  | Approximate Interval Between Onset and Death<br>1 hr<br>2 weeks<br>year |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Cerebral vascular malformation<br>Cerebral vascular accidents   |  |   |  |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |   |
| 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |   |  |  |  |   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |  |  |  |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  |   | 28a. Date of Injury (Month, Day Year)  |   | 28b. Time of injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred                                       |
|   |  |   | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   | 29b. Signature and title of certifier<br>Jeremy V. Cooke M.D.  |   |   | 29c. License number<br>D04602                          |  | 29d. Date signed (Month, Day, Year)<br>2/5/96  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Jeremy V. Cooke M.D. 10400 Conn. Ave. Kensington Md.  |  |   |  |   |   |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br>FEB 08 1996  |  |   |  | 32. Registrar's Signature<br>John Davidson Randall  |   |  |  |  |   |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

State  
Registrar



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR  |  |   |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE                                   |  |  |  | 96 04913  |  |                    |  |
|---|--|---|--|---|--|--|--|---|--|--------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)  |  |   |  | 2. DATE OF DEATH  |  |  |  | 3. TIME OF DEATH  |  |                    |  |
| GRACE H BEAN  |  |   |  | MONTH DAY YEAR<br>JANUARY 31, 1996  |  |  |  | 3:13 A.M.   |  |                    |  |
| 4. SOCIAL SECURITY NUMBER   |  | 5. SEX                                      |  | 6. AGE (In yrs. last birthday)  |  | 7. DATE OF BIRTH                               |  | 8. BIRTHPLACE (State or Foreign Country)  |  | 9. COUNTY OF DEATH |  |
| 214-32-7871   |  | 1 M 2 F                                     |  | 78 YRS.   |  | Oct. 20, 1917                                  |  | S. C.   |  | S. C.              |  |
| 9a. FACILITY NAME (If not institution, give street and number)  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH   |  |  |  | 9c. COUNTY OF DEATH   |  |                    |  |
| Southern Maryland Hospital  |  |   |  | Clinton   |  |  |  | Prince Georges  |  |                    |  |
| 10a. STATE  |  |   |  | 10b. COUNTY   |  | 10c. CITY, TOWN OR LOCATION                    |  | 10d. INSIDE CITY LIMITS?  |  |                    |  |
| Md.   |  |   |  | Prince Georges  |  | Clinton  |  | 1 X YES 2 NO  |  |                    |  |
| 10e. STREET AND NUMBER  |  |   |  | 10f. ZIP CODE   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?   |  |                    |  |
| 9211 Stuart Lane  |  |   |  | 20735   |  |  |  | U.S.A.  |  |                    |  |
| 11. MARITAL STATUS  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? |  | 13. WAS DECEDENT OF HISPANIC ORIGIN?  |  | 14. RACE — American Indian, Black, White, etc. |  |   |  |                    |  |
| 1 X Never Married 2 Married   |  | 1 X YES 2 NO                                |  | 1 X YES 2 NO  |  | Specify: Black                                 |  |   |  |                    |  |
| 3 X Widowed 4 Divorced  |  | IF YES, GIVE WAR OR DATES                   |  | Specify:  |  |  |  |   |  |                    |  |
| 15. DECEDENT'S EDUCATION  |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |                    |  |
| Elementary/Secondary (0-12)   |  |   |  | College (1-4 or 5+)   |  |  |  | Housekeeper   |  |                    |  |
| 6th   |  |   |  |   |  |  |  | Private Industry  |  |                    |  |
| 17. FATHER'S NAME (First, Middle, Last)   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)   |  |  |  |   |  |                    |  |
| Alonzo Abney  |  |   |  | Barbara Rhines  |  |  |  |   |  |                    |  |
| 19a. INFORMANT'S NAME (Type/Print)  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |  |  |  |   |  |                    |  |
| Mary Taylor (Daughter)  |  |   |  | 720 Emerson Street, N.E., Wash., D. C. 20017  |  |  |  |   |  |                    |  |
| 20a. METHOD OF DISPOSITION  |  | 20b. PLACE AND DATE OF DISPOSITION          |  | 20c. LOCATION — City or Town, State   |  |  |  |   |  |                    |  |
| 1 X Burial 2 Cremation 3 Removal from State   |  | Harmony Memorial                            |  | Landover, Md.   |  |  |  |   |  |                    |  |
| 4 Donation 5 Other (Specify)  |  |   |  |   |  |  |  |   |  |                    |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE   |  |   |  | 22. NAME AND ADDRESS OF FACILITY  |  |  |  |   |  |                    |  |
| R. N. Horton  |  |   |  | R. N. Horton Co. Morticians, Inc.   |  |  |  |   |  |                    |  |
|   |  |   |  | 600 Kennedy Street, N. W.   |  |  |  |   |  |                    |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. |  |   |  |   |  |  |  | Approximate Interval Between Onset and Death  |  |                    |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiovascular arrest   |  |   |  |   |  |  |  | New onset   |  |                    |  |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  |   |  |   |  |  |  |   |  |                    |  |
| b. End stage renal disease  |  |   |  |   |  |  |  | 1 month   |  |                    |  |
| c. Dentia   |  |   |  |   |  |  |  | old   |  |                    |  |
| d. Contracted extremities   |  |   |  |   |  |  |  | old   |  |                    |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  |  |  |   |  |                    |  |
| Anemia  |  |   |  |   |  |  |  |   |  |                    |  |
| G-T feeding   |  |   |  |   |  |  |  |   |  |                    |  |
| CVA changes   |  |   |  |   |  |  |  |   |  |                    |  |
| Diabetes mel  |  |   |  |   |  |  |  |   |  |                    |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN   |  |   |  |   |  |  |  |   |  |                    |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?  |  |   |  | 26. PLACE OF DEATH (Check only one)   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?  |  |                    |  |
| 1 YES 2 NO  |  |   |  | HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA   |  |  |  | 1 YES 2 NO  |  |                    |  |
| 27. MANNER OF DEATH   |  |   |  | 28a. DATE OF INJURY   |  |  |  | 28b. TIME OF INJURY   |  |                    |  |
| 1 Natural 2 Accident 3 Suicide 4 Homicide   |  |   |  | Month, Day, Year  |  |  |  | M 1 YES 2 NO  |  |                    |  |
| 5 Pending Investigation 6 Could not be determined   |  |   |  |   |  |  |  |   |  |                    |  |
|   |  |   |  | 28c. INJURY AT WORK?  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |                    |  |
|   |  |   |  | 1 YES 2 NO  |  |  |  |   |  |                    |  |
|   |  |   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)        |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)        |  |                    |  |
|   |  |   |  |   |  |  |  |   |  |                    |  |
| 29a. CERTIFIER (Check only one)   |  |   |  |   |  |  |  | 29c. LICENSE NUMBER   |  |                    |  |
| 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |  |  | D25640  |  |                    |  |
| 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                            |  |   |  |   |  |  |  | 29d. DATE SIGNED (Month, Day, Year)   |  |                    |  |
|   |  |   |  |   |  |  |  | JAN. 31, 1996   |  |                    |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER   |  |   |  |   |  |  |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) |  |                    |  |
| R. Daniel M.D.  |  |   |  |   |  |  |  | 1328 Southern Ave. #202 Washington DC 20032   |  |                    |  |
| 31. DATE FILED (Month, Day, Year)   |  |   |  |   |  |  |  | 32. REGISTRAR'S SIGNATURE   |  |                    |  |
| FEB 07 1996   |  |   |  |   |  |  |  | Julia Davidson Randall  |  |                    |  |

1931



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 96 049114

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

EUGENE Robert

BOVEY

2. Date of Death  
Month Day Year  
JANUARY 31 1996 0944

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

220-26-4895

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

64

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
March 13, 1931

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

12701 Ardennes Avenue

10f. Zip Code

20851

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married

3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: Korea

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Nurseryman

16b. Kind of Business/Industry

Landscaping

17. Father's Name (First, Middle, Last)

James Bovey

18. Mother's Name (First, Middle, Maiden Surname)

Mildred Gluck

19a. Informant's Name/Relationship (Type, Print)

Betty S. Bovey

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12701 Ardennes Avenue, Rockville, Maryland 20851

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parklawn Memorial Park

Date

February 2, 1996

20c. Location - City or Town, State

Rockville, Maryland

21. Signature of Funeral Service Licensee

Michael P. Kutta

M00348

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/

Rockville, Inc., 300 W. Montgomery Ave.

Rockville, Maryland 20850-2805

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Subacute Bacterial Endocarditis

Due to (or as a consequence of):

weeks

b. Aortic Stenosis

Due to (or as a consequence of):

years

c. Coronary Artery Disease

Due to (or as a consequence of):

unknown

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Renal Failure

Respiratory Insufficiency

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural

2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

5 ☐ Pending Investigation

6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Medical Examiner

2 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

D.R. Rosing, M.D.

29c. License number

D32193

29d. Date signed (Month, Day, Year)

1/31/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D.R. Rosing, M.D.

6410 ROCKLEDGE DR. SUITE 200

BETHESDA MD 20817

31. Date filed (Month, Day, Year)

FEB 06 1996

32. Registrar's Signature

John Andrew Randall

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State  
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR  |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 96 04915  |  |                                |  |  |  |
|---|--|--|--|---|--|--|--|---|--|--------------------------------|--|--|--|
| CERTIFICATE OF DEATH  |  |  |  | REG. NO.  |  |  |  |   |  |                                |  |  |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br>William Callender, Sr.  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>Feb 6, 1996   |  |  |  | 3. TIME OF DEATH<br>7:59PM M  |  |                                |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br>102-26-9432  |  | 5. SEX<br>M <input checked="" type="checkbox"/> F <input type="checkbox"/>   |  | 6. AGE (In yrs. last birthday)<br>61 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.  |  |                                |  |  |  |
| 7. DATE OF BIRTH<br>(Month, Day, Year)<br>Nov 22, 1934  |  |  |  | 8. BIRTHPLACE (State or Foreign Country)<br>New York  |  |  |  |   |  |                                |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Apt 2 325 Cumberland St   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Cumberland   |  |  |  | 9c. COUNTY OF DEATH<br>Allegany   |  |                                |  |  |  |
| 10a. STATE<br>Maryland  |  |  |  | 10b. COUNTY<br>Allegany   |  | 10c. CITY, TOWN OR LOCATION<br>Cumberland  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |                                |  |  |  |
| 10e. STREET AND NUMBER<br>325 Cumberland Street   |  |  |  | 10f. ZIP CODE<br>21502  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  |                                |  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>Korean War   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: Black                     |  |   |  |                                |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (14 or 5+) 12  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>clerk  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Railroad   |  |   |  |                                |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Charles Ross   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Greta Carl   |  |  |  |   |  |                                |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Bernice Redman  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>705 Frederick St. Cumberland, Md. 21502  |  |  |  |   |  |                                |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Rocky Gap Vet. Cemetery 2/2/96  |  | 20c. LOCATION — City or Town, State<br>Cumberland, Maryland   |  |  |  |   |  |                                |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Eunt A. Riley Jr.  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Leasure-Stein, Inc. 230 Baltimore Ave.<br>Cumberland, Md. 21502   |  |  |  |   |  |                                |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → Arteriosclerotic heart disease<br>s. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |  |  |   |  |  |  | Approximate Interval Between Onset and Death<br>8 yrs   |  |                                |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>hypertension  |  |  |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |  |                                |  |  |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  |   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |                                |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |   |  |                                |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE NOW INJURY OCCURRED   |  |                                |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |                                |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Dpty Med Ex  |  | 29c. LICENSE NUMBER<br>D 09157 |  | 29d. DATE SIGNED (Month, Day, Year)<br>Feb 6, 1996 |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Paul Snow, M.D. 124 w 3rd st Cumb MD 21502   |  |  |  |   |  |  |  |   |  |                                |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>FEB 12 1996  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>John Anderson  |  |  |  |   |  |                                |  |  |  |

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04916

|  |  |   |  |   |  |  |  |   |  |   |  |
|--|--|---|--|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Emily Marguerite Council</i>  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><i>February 11, 1996</i>  |  | 3. TIME OF DEATH<br>HOURS MINUTES<br><i>1:30 P</i>                               |  |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><i>579-48-6340</i>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><i>81</i> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>May 16, 1914</i>                    |  | 8. BIRTHPLACE (State or Foreign Country)<br><i>Maryland</i>   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>8309 James Street (RESIDENCE)</i>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Upper Marlboro</i>  |  |  | 9c. COUNTY OF DEATH<br><i>Prince George's</i>                              |   |  |   |  |
| RESIDENCE OF DECEDENT  |  |   |  |   |  |  |  |   |  |   |  |
| 10a. STATE<br><i>Maryland</i>  |  | 10b. COUNTY<br><i>Prince George</i>   |  | 10c. CITY, TOWN OR LOCATION<br><i>Upper Marlboro</i>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO       |  |   |  |
| 10e. STREET AND NUMBER<br><i>8309 James Street (RESIDENCE)</i>   |  |   |  | 10f. ZIP CODE<br><i>20772</i>   |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>United States</i>                      |   |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><i>White</i> |   |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>College</i>   |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>Homemaker</i>   |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>At Home</i>                           |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>William Alfred Bowles</i>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Rena Olivia Lassiter</i>  |  |  |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Claude L. Council, Sr.</i>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>8309 James Street, Upper Marlboro, Maryland</i>   |  |  |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Cedar Hill Cemetery Feb 15, 1996</i>  |  |   | 20c. LOCATION — City or Town, State<br><i>Suitland, Maryland</i> |  |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Charles L. Belanger</i>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><i>Lee Funeral Home, Inc 6633 Old Alexandria Ferry Rd., Clinton</i>   |  |  |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Ante-natal cerebral-vascular disease</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |   |  |  |  | Approximate interval between Onset and Death  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |   |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>August P. Rodriguez MD</i>   |  |   |  |   |  | 29c. LICENSE NUMBER<br><i>D21230</i>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>February 14, 1996</i>                                       |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>August P. Rodriguez MD, 5009 Payburn Ct. Cr. Sp. Md 20748</i>  |  |   |  |   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><i>FEB 14 1996</i>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson Randall</i>   |  |  |  |   |  |   |  |

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1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the study and the objectives of the research. It also provides a brief overview of the methodology used in the study.

2. The second part of the report is a detailed description of the study area. It includes information about the location of the study area, the population of the study area, and the characteristics of the study area. It also discusses the data sources used in the study.

3. The third part of the report is a detailed description of the study results. It includes information about the findings of the study, the conclusions drawn from the study, and the implications of the study. It also discusses the limitations of the study.

4. The fourth part of the report is a detailed description of the study conclusions. It includes information about the overall findings of the study, the conclusions drawn from the study, and the implications of the study. It also discusses the limitations of the study.

5. The fifth part of the report is a detailed description of the study conclusions. It includes information about the overall findings of the study, the conclusions drawn from the study, and the implications of the study. It also discusses the limitations of the study.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR  |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 96 049117  |  |   |  |
|---|--|--|--|---|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)  |  |  |  | 2. DATE OF DEATH  |  |   |  | 3. TIME OF DEATH   |  |   |  |
| Audrey Ruth Cook  |  |  |  | Feb 9, 1996   |  |   |  | 8:25 A M   |  |   |  |
| 4. SOCIAL SECURITY NUMBER   |  | 5. SEX   |  | 6. AGE (In yrs. last birthday)  |  | 7. DATE OF BIRTH  |  | 8. BIRTHPLACE (State or Foreign Country)                                     |  |   |  |
| 577-18-6277   |  | 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                 |  | 75 YRS.   |  | July 4, 1920  |  | Branchenridge, PA  |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH   |  |   |  | 9c. COUNTY OF DEATH  |  |   |  |
| Prince George's Hospital  |  |  |  | Cheverly  |  |   |  | Prince George's  |  |   |  |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |   |  |  |  |   |  |
| 10a. STATE  |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION   |  | 10d. INSIDE CITY LIMITS?  |  |  |  |   |  |
| Maryland  |  | Prince George  |  | Morningside   |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |  |  |   |  |
| 10e. STREET AND NUMBER  |  |  |  | 10f. ZIP CODE   |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?  |  |   |  |
| 4010 Forest Grove Road  |  |  |  | 20746   |  |   |  | United States  |  |   |  |
| 11. MARITAL STATUS  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN?  |  | 14. RACE — American Indian, Black, White, etc.                          |  |  |  |   |  |
| 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>Specify:   |  | Specify:<br>White   |  |  |  |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)  |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |   |  |
| Elementary/Secondary (0-12) 12 College (1-4 or 5 +)   |  |  |  | Secretarial   |  |   |  | U.S. Government  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)   |  |   |  |  |  |   |  |
| Jacob Smith Walker  |  |  |  | Mabel Anna Wegner   |  |   |  |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)   |  |   |  |  |  |   |  |
| Edson Cook— (SON)   |  |  |  | P.O. BOX 32, Harwood, Maryland 20776  |  |   |  |  |  |   |  |
| 20a. METHOD OF DISPOSITION  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)                      |  | DATE  |  | 20c. LOCATION — City or Town, State                                     |  |  |  |   |  |
| 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | Fort Lincoln Cemetery  |  |   |  | Brentwood, Maryland   |  |  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE   |  |  |  | 22. NAME AND ADDRESS OF FACILITY  |  |   |  |  |  |   |  |
|   |  |  |  | Lee Funeral Home, Inc 6633<br>Old Alexandria Ferry Road, Clinton MD   |  |   |  |  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |  |  |   |  |   |  | Approximate Interval Between Onset and Death                                 |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →   |  |  |  |   |  |   |  | 4  |  |   |  |
| a. <u>infection</u>   |  |  |  |   |  |   |  |  |  |   |  |
| b. <u>metastatic ovarian cancer</u>   |  |  |  |   |  |   |  |  |  |   |  |
| c. <u></u>  |  |  |  |   |  |   |  |  |  |   |  |
| d. <u></u>  |  |  |  |   |  |   |  |  |  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  |  |  |  |   |  |   |  |  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |  |
|   |  |  |  |   |  |   |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO      |  | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |  |   |  |   |  |  |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?  |  |  |  | 26. PLACE OF DEATH (Check only one)   |  |   |  |  |  |   |  |
| 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |   |  |
| 27. MANNER OF DEATH   |  | 28a. DATE OF INJURY  |  | 28b. TIME OF INJURY   |  | 28c. INJURY AT WORK?  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  |
| 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  |  |  |   |  | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO            |  |  |  |   |  |
| 29a. CERTIFIER (Check only one)   |  |  |  | 29b. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 29c. LOCATION (Street and Number or Rural Route Number, City or Town, State) |  |   |  |
| 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER   |  |  |  | 29c. LICENSE NUMBER   |  |   |  | 29d. DATE SIGNED (Month, Day, Year)  |  |   |  |
|   |  |  |  | D17605  |  |   |  | 2/9/96   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print)   |  |  |  |   |  |   |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)   |  |  |  | 32. REGISTRAR'S SIGNATURE   |  |   |  |  |  |   |  |
| FEB 14 1996   |  |  |  | Julia Davidson Randall  |  |   |  |  |  |   |  |





96 04918

1 FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>GEORGE CARR</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>FEB</b> DAY <b>3</b> YEAR <b>1996</b>   |  | 3. TIME OF DEATH<br><b>0630</b> M  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>217283513</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>66</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>5-9-29</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>VIRGINIA</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Veterans Hospital</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>  |  |
| 9c. COUNTY OF DEATH<br><b>BALTIMORE</b>  |  |  |  | 10a. STATE<br><b>VIRGINIA</b>  |  | 10b. COUNTY<br><b>Accomack</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Hornstown</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>4651 Fleming Rd</b>   |  |
| 10f. ZIP CODE<br><b>23395</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>  |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>CRANE operator</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Steel company</b>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Hezekiah Carr SR.</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Viola Paddy</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>JANET CARR</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4651 Fleming Rd Hornstown, VA.</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>MT Nebo Church 2/11/96</b>   |  | 20c. LOCATION — City or Town, State<br><b>ONANCK, VA.</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Keith E. Wharton</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Wharton Funeral Home<br/>22171 Wharton Rd Accomack, VA</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CHRONIC OBSTRUCTIVE LUNG DISEASE</b>  |  |  |  |  |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |  |
| Sequitentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  |  |  |  |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |  |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  |  |  |  |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input type="checkbox"/> NO  |  |
| 28c. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  |
| 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Darryl Hill MD</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>147625450</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>2/3/96</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>DARRYL HILL MD. UNIV MARYLAND HOSP, BACT MD</b>  |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 12 1996</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>John Davidson Randall</b>  |  |  |  |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR  |  |  |   | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |                                |   |  | 96 04919   |  |
|---|--|--|---|---|--------------------------------|---|--|--|--|
| CERTIFICATE OF DEATH  |  |  |   | REG. NO.  |                                |   |  |  |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Marguerite Georgia Cloman   |  |  |   | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>02 04 96  |                                | 3. TIME OF DEATH<br>12:30 a <sup>m</sup>  |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br>218-14-8266  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br>72 YRS. | IF UNDER 1 YEAR<br>MONTHS DAYS  | IF UNDER 24 HRS.<br>HOURS MIN. | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>10-14-23  |  | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Meridian Nursing Center-Heritage  |  |  |   | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Dundalk  |                                | 9c. COUNTY OF DEATH<br>Baltimore  |  |  |  |
| RESIDENCE OF DECEDENT   |  |  |   |   |                                |   |  |  |  |
| 10a. STATE<br>Maryland  |  | 10b. COUNTY<br>Harford   |   | 10c. CITY, TOWN OR LOCATION<br>Bel Air  |                                | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |  |  |
| 10e. STREET AND NUMBER<br>520 Mast Street   |  | 10f. ZIP CODE<br>21014   |   | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |                                |   |  |  |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |   | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |                                | 14. RACE — American Indian, Black, White, etc.<br>Specify: white                                    |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Homemaker                       |   | 16b. KIND OF BUSINESS/INDUSTRY<br>Home  |                                |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>George Leonard Cloman  |  |  |   | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Polly E. Hale  |                                |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>J. Janelle Anderson   |  |  |   | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2853 Forge Hill Road, Bel Air, Maryland 21015  |                                |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Mt. Zion Cemetery 2/6/96                                      |   | 20c. LOCATION — City or Town, State<br>Bel Air, Maryland  |                                |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Stephen A. Hughes</i>   |  | 22. NAME AND ADDRESS OF FACILITY<br>Howard K. McComas III Funeral Home, P.A.<br>1317 Cokesbury Road, Abingdon, Md. 21009                         |   |   |                                |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → Ovarian Carcinoma<br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |   |   |                                |   |  | Approximate Interval Between Onset and Death<br>4 months   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |   |   |                                |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |   |   |                                |   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |   | 28b. TIME OF INJURY<br>M  |                                | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  | 28d. DESCRIBE HOW INJURY OCCURED   |  |
|   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |                                |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Harjit Singh</i> (Attending Physician) M.D.  |   | 29c. LICENSE NUMBER<br>D14160   |                                | 29d. DATE SIGNED (Month, Day, Year)<br>02/05/96   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Harjit Singh, M.D. 5410-A Ritchie Highway Baltimore, Md. 21225   |  |  |   |   |                                |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>FEB 6 1996   |  | 32. REGISTRAR'S SIGNATURE<br><i>Michael Randall</i>  |   |   |                                |   |  |  |  |

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 96 04920

|  |  |   |   |   |  |
|--|--|---|---|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Allan Crawford Cameron</b>                          |   | 2. Date of Death<br>Month <b>February</b> Day <b>8</b> Year <b>1996</b>   |   | 3. Time of Death<br><b>1320</b>                                |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Calvert Memorial Hospital</b> |   | 4b. City, Town, or Location of Death<br><b>Prince Frederick Calvert</b>   |   | 4c. County of Death  |
| Funeral<br>Director  | 5. Social Security Number<br><b>212-20-3295</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>72</b> Yrs.  | If Under 1 Year<br>Months <b>0</b> Days <b>0</b>  | If Under 24 Hrs.<br>Hours <b>0</b> Min. <b>0</b>               |
|  | 8. Date of Birth (Month, Day, Year)<br><b>June 18, 1923</b>  |   | 9. Birthplace (State or Foreign Country)<br><b>New York</b>   |   |  |
| Usual Residence of Decedent  |  |   |   |   |  |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Calvert</b>   |   | 10c. City, Town or Location<br><b>Lusby</b>   |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |   |   |  |
| 10e. Street and Number<br><b>13104 Joy Road</b>  |  |   | 10f. Zip Code<br><b>20657</b>   |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>                 |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>World War II</b>   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |   |   |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>1 year</b>   |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Electrical Engineer</b> |   | 16b. Kind of Business/Industry<br><b>Government Contractor</b> |
| 17. Father's Name (First, Middle, Last)<br><b>Hugh Cameron</b>   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Jean McClaine</b>   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Dolores Alexine Cameron</b>   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>13104 Joy Rd., Lusby, MD 20657</b>  |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MD Veterans Cemetery</b>   |   | 20c. Location - City or Town, State<br><b>Cheltenham, Maryland</b>  |  |
| 21. Signature of Funeral Service Licensee<br><i>Michael K. Gardiner</i>  |  |   | 22. Name and Address of Facility<br><b>Mattingley-Gardiner Funeral Home, P.A.<br/>P.O. Box 270, Leonardtown, Maryland 20650</b>         |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |   |   |  |
| Immediate Cause (Final disease or condition resulting in death)  |  | a. <b>Anoxic Encephalopathy</b><br>Due to (or as a consequence of):   |   | Approximate Interval Between Onset and Death<br><b>48 Hrs.</b>  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  | b. <b>Ventricular tachycardia</b><br>Due to (or as a consequence of):   |   | <b>48 Hrs.</b>  |  |
|  |  | c. <b>Coronary Artery Disease</b><br>Due to (or as a consequence of):   |   | <b>14 Yrs.</b>  |  |
|  |  | d.  |   |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |   |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>   |  |
|  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   | 28d. Describe how injury occurred   |  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |   |  |
| 29b. Signature and title of certifier<br><i>Mark Kushner</i>   |  | 29c. License number<br><b>AK 9352369</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>February 8, 1996</b>  |  |
| 30. Name and address of person who completed cause of death (item 23e) (Type, Print)<br><b>Mark Kushner M.D. Prince Frederick, MD 20678</b>  |  |   |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB - 9 1996</b>   |  | 32. Registrar's Signature<br><i>John Davidson-Randall</i>   |   |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR   |  |   |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 96 04921  |  |  |  |   |  |   |  |
|--|--|---|--|--|--|---|--|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)   |  |   |  | 2. DATE OF DEATH   |  |   |  | 3. TIME OF DEATH  |  |  |  |   |  |   |  |
| Jasper Jefferson Crowley   |  |   |  | February 3, 1996   |  |   |  | 10:05 P.M.  |  |  |  |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER  |  | 5. SEX  |  | 6. AGE (In yrs. last birthday)   |  | IF UNDER 1 YEAR   |  | IF UNDER 24 HRS.  |  | 7. DATE OF BIRTH   |  | 8. BIRTHPLACE (State or Foreign Country)                                |  |   |  |
| 226-14- 0873   |  | 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F    |  | 92 YRS.  |  | MONTHS DAYS HOURS MIN.  |  |   |  | Sep 28, 1903   |  | Virginia  |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)   |  |   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH   |  |   |  | 9c. COUNTY OF DEATH  |  |   |  |   |  |
| St. Mary's Nursing Center  |  |   |  |  |  | Leonardtwn  |  |   |  | St. Mary's   |  |   |  |   |  |
| RESIDENCE OF DECEDENT  |  |   |  |  |  |   |  |   |  |  |  |   |  |   |  |
| 10a. STATE   |  | 10b. COUNTY   |  | 10c. CITY, TOWN OR LOCATION  |  |   |  | 10d. INSIDE CITY LIMITS?  |  |  |  |   |  |   |  |
| Maryland   |  | St. Mary's  |  | Mechanicsville   |  |   |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |  |  |   |  |   |  |
| 10e. STREET AND NUMBER   |  |   |  |  |  | 10f. ZIP CODE   |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?  |  |   |  |   |  |
| 845 Old Route Five   |  |   |  |  |  | 20659   |  |   |  | U.S.A.   |  |   |  |   |  |
| 11. MARITAL STATUS   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?                             |  | 13. WAS DECEDENT OF HISPANIC ORIGIN?   |  |   |  | 14. RACE — American Indian, Black, White, etc.                          |  |  |  |   |  |   |  |
| 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married  |  | 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |   |  | Specify: White  |  |  |  |   |  |   |  |
| 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | IF YES, GIVE WAR OR DATES   |  | Specify:   |  |   |  |   |  |  |  |   |  |   |  |
|  |  | World War II  |  |  |  |   |  |   |  |  |  |   |  |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)  |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)   |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |  |  |   |  |   |  |
| Elementary/Secondary (0-12)  |  |   |  | College (1-4 or 5+)  |  |   |  | Maintenance Foreman   |  |  |  | U.S. Government   |  |   |  |
| 12th Grade   |  |   |  |  |  |   |  |   |  |  |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)  |  |   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)   |  |   |  |  |  |   |  |   |  |
| Hunter Wallace Crowley   |  |   |  |  |  | Emma Clara Lee  |  |   |  |  |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)   |  |   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |  |   |  |  |  |   |  |   |  |
| Helen Clark  |  |   |  |  |  | Rt. 2 Box 298-N, Heathville, VA 22473   |  |   |  |  |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION   |  |   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)  |  |   |  | 20c. LOCATION — City or Town, State                                     |  |  |  |   |  |   |  |
| 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State  |  |   |  | Metropolitan Crematory 2/6/96  |  |   |  | Alexandria, Virginia  |  |  |  |   |  |   |  |
| 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |   |  |  |  |   |  |   |  |  |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  |  |   |  | 22. NAME AND ADDRESS OF FACILITY   |  |   |  |   |  |  |  |   |  |   |  |
| <i>Michael K. Gardiner</i>   |  |   |  | Mattingley-Gardiner Funeral Home, P.A.<br>P.O. Box 270, Leonardtown, Maryland 20650  |  |   |  |   |  |  |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |  |  |   |  |   |  |  |  | Approximate Interval Between Onset and Death                            |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  |   |  |  |  |   |  |   |  |  |  | 5-Days  |  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  |   |  |  |  |   |  |   |  |  |  |   |  |   |  |
| a. <i>Terminal pneumonia</i>   |  |   |  |  |  |   |  |   |  |  |  |   |  |   |  |
| b. <i>Chronic urinary tract infection - asymptomatic 10/95</i>   |  |   |  |  |  |   |  |   |  |  |  |   |  |   |  |
| c.   |  |   |  |  |  |   |  |   |  |  |  |   |  |   |  |
| d.   |  |   |  |  |  |   |  |   |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  |   |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |  |
| <i>COMPRESSION FRACTURES - LUMBAR VERTEBRAE</i>  |  |   |  |  |  |   |  |   |  |  |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>  |  |   |  |  |  |   |  |   |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?   |  |   |  | 26. PLACE OF DEATH (Check only one)  |  |   |  |   |  |  |  |   |  |   |  |
| 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |   |  | HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |  |  |   |  |   |  |
| 27. MANNER OF DEATH  |  |   |  | 28a. DATE OF INJURY  |  | 28b. TIME OF INJURY   |  | 28c. INJURY AT WORK?  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  |   |  |
| 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |  |   |  | (Month, Day, Year)   |  | M   |  | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO            |  |  |  |   |  |   |  |
|  |  |   |  | 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |  |   |  |   |  |
|  |  |   |  |  |  |   |  |   |  |  |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)  |  |   |  |  |  |   |  |   |  |  |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)   |  |
| 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  |  |   |  |   |  |  |  | D 02205   |  | 2-6-96  |  |
| 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |  |  |   |  |   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  |  |   |  |  |  |   |  |   |  |  |  |   |  |   |  |
| <i>J. Roy Guyther, M.D.</i>  |  |   |  |  |  |   |  |   |  |  |  |   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  |  |   |  |  |  |   |  |   |  |  |  |   |  |   |  |
| J. Roy Guyther, M.D. Mechanicsville, MD 20659  |  |   |  |  |  |   |  |   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)  |  |   |  | 32. REGISTRAR'S SIGNATURE  |  |   |  |   |  |  |  |   |  |   |  |
| FEB - 9 1996   |  |   |  | <i>J. Roy Guyther</i>  |  |   |  |   |  |  |  |   |  |   |  |

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR   |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 96 04922  |  |  |  |  |  |
|--|--|--|--|--|--|---|--|---|--|--|--|--|--|
| CERTIFICATE OF DEATH   |  |  |  | REG. NO.   |  |   |  |   |  |  |  |  |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Helen Demko Coogan   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>February 8, 1996   |  |   |  | 3. TIME OF DEATH<br>15:35 A.M.  |  |  |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br>192-20-8578   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 8. AGE (In yrs. last birthday)<br>64 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS                            |  | IF UNDER 24 HRS.<br>HOURS MIN.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>May 13, 1931 |  | 8. BIRTHPLACE (State or Foreign Country)<br>Pennsylvania |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>St. Mary's Hospital  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Leonardtwn  |  |   |  | 9c. COUNTY OF DEATH<br>St. Mary's   |  |  |  |  |  |
| RESIDENCE OF DECEDENT  |  |  |  |  |  |   |  |   |  |  |  |  |  |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>St. Mary's  |  | 10c. CITY, TOWN OR LOCATION<br>California  |  |   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |  |  |  |  |
| 10e. STREET AND NUMBER<br>3187 North Town Creek Drive  |  |  |  | 10f. ZIP CODE<br>20619   |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>United States  |  |  |  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                                 |  |  |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) - - - -   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Real Estate Agent   |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Real Estate   |  |  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>John Demko  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Julia Minjack   |  |   |  |   |  |  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Sean P. Coogan   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>104 Hill Crest Drive, Hollywood, Maryland 20636   |  |   |  |   |  |  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Immaculate Heart of Mary 2/12/96                              |  | DATE   |  | 20c. LOCATION — City or Town, State<br>Lexington Park, MD |  |   |  |  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Edward N. Brinsfield, Jr. M00052  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Brinsfield Funeral Home<br>P.O. Box 279, Leonardtown, Maryland 20650   |  |   |  |   |  |  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Cardiorespiratory arrest</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <u>Seizure disorder, left hemiplegia</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <u>Metastatic tumors of brain</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Approximate Interval Between Onset and Death<br>0d 9h<br>0d 9h |  |  |  |  |  |   |  |   |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>COPD</u>  |  |  |  |  |  |   |  |   |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |  |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide  |  |  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M                                  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  | 28d. DESCRIBE HOW INJURY OCCURRED                      |  |  |  |
|  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                        |  |  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |   |  |   |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Youngsik Moon M.D. Attending  |  |  |  | 29c. LICENSE NUMBER<br>D09178  |  |   |  | 29d. DATE SIGNED (Month, Day, Year)<br>Feb 9, 1996  |  |  |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Youngsik Moon, M.D. Hollywood, Maryland 20636   |  |  |  |  |  |   |  |   |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>FEB -9 1996   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>John Davidson-Randall   |  |   |  |   |  |  |  |  |  |

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR  |  |   |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 96 04923  |  |  |  |
|--|--|---|--|--|--|--|--|---|--|--|--|
| CERTIFICATE OF DEATH   |  |   |  | REG. NO.   |  |  |  |   |  |  |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br>James Leroy Cox, Sr.   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>February 11, 1996  |  |  |  | 3. TIME OF DEATH<br>8:25 a. M   |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br>482-36-8376   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>58 YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>April 29, 1937                                |  | 8. BIRTHPLACE (State or Foreign Country)<br>Iowa  |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>530 Widow Lane (Residence)   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Mechanicsville  |  |  |  | 9c. COUNTY OF DEATH<br>St. Mary's   |  |  |  |
| RESIDENCE OF DECEDENT  |  |   |  |  |  |  |  |   |  |  |  |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>St. Mary's   |  | 10c. CITY, TOWN OR LOCATION<br>Mechanicsville  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO       |  |  |  |
| 10e. STREET AND NUMBER<br>530 Widow Lane   |  |   |  | 10f. ZIP CODE<br>20659   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>Vietnam |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White  |  |  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12th grade<br>College (1-4 or 5+) College   |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Analyst  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Government Contractor   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Floyd Ervin Cox, Sr.  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Evelyn Sadey Sutton   |  |  |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Wilma Jean Cox   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>530 Widow Ln., Mechanicsville, Maryland 20659   |  |  |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Charles Memorial Gardens 2/15/96   |  |  |  | DATE<br>2/15/96  |  | 20c. LOCATION — City or Town, State<br>Leonardtwn, Maryland   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Michael L. Gardiner</i>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>Mattingley-Gardiner Funeral Home, P.A.<br>P.O. Box 270, Leonardtown, Maryland 20650  |  |  |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Probable Myocardial Infarction</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b.<br>c.<br>d.<br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> |  |   |  |  |  |  |  | Approximate Interval Between Onset and Death<br>Sec   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide 4 <input type="checkbox"/>   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED<br>N/A  |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br>N/A  |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>William Boyd II</i>  |  |  |  | 29c. LICENSE NUMBER<br>D14285   |  | 29d. DATE SIGNED (Month, Day, Year)<br>2-12-96   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Dr. William Boyd, II, M.D. Leonardtown, Maryland 20650  |  |   |  | 31. DATE FILED (Month, Day, Year)<br>FEB 13 1996   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>J. A. Davidson-Randall</i>  |  |  |  |

550:

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04924

|  |  |  |   |   |  |  |   |
|--|--|--|---|---|--|--|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>MARK PAT CARROLL</b>  |  |   | 2. Date of Death<br>Month Day Year<br><b>FEBRUARY 04 1996</b>   |  | 3. Time of Death<br><b>2:04 AM</b>   |   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>MEMORIAL HOSPITAL</b>   |  |   | 4b. City, Town, or Location of Death<br><b>CUMBERLAND</b>   |  | 4c. County of Death<br><b>ALLEGANY</b>   |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>215-62-3140</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>28</b> Yrs.  | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Dec. 18, 1967</b>                                    | 9. Birthplace (State or Foreign Country)<br><b>Washington, DC</b>                           |
|  | Usual Residence of Decedent  |  |   |   |  |  |   |
| To Be Completed by Funeral Director  | 10a. State<br><b>Maryland</b>  | 10b. County<br><b>Prince George's</b>                                      | 10c. City, Town or Location<br><b>New Carrollton</b>  |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |
|  | 10e. Street and Number<br><b>6208 87th Avenue</b>  |  |   | 10f. Zip Code<br><b>20784</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |
|  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                     |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)  |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Electrician</b>   |  | 16b. Kind of Business/Industry<br><b>University of Maryland</b>                                |   |
|  | 17. Father's Name (First, Middle, Last)<br><b>Martin Joseph Carroll, Jr.</b>   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Roberta Ann Thunell</b>   |  |  |   |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Martin Joseph Carroll, Jr.</b>  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6208 87th Avenue, New Carrollton, Md. 20784</b>   |  |  |   |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Resurrection Cemetery</b>  |   | Date<br><b>2/8/96</b>  |  | 20c. Location - City or Town, State<br><b>Clinton, Md.</b>                                  |
|  | 21. Signature of Funeral Service Licensee<br><b>W.B. Garcia</b>  |  |   | 22. Name and Address of Facility<br><b>Francis Gasch Sons Funeral Home<br/>4739 Baltimore Avenue, Hyattsville, Md. 20781</b>  |  |  |   |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><b>Stab Wound to Chest</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):       |  |   |   |  |  |   |
|  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |   |  |  |   |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |   |   |  |  |   |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |   |   |  |  |   |
| To Be Completed by Physician/Medical Examiner  | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |
|  | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)<br><b>2-4-96</b>   |   | 28b. Time of Injury<br><b>0048 M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>Residence</b>   |  | 28d. Describe how injury occurred<br><b>subject stabbed</b>   |   |  |  |   |
|  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>32 W. Medford St. Baltimore, MD</b>   |  |   |   |  |  |   |
|  | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |   |  |  |   |
| State Registrar  | 29b. Signature and title of certifier<br><b>John L. Locke MD</b>   |  |   | 29c. License number<br><b>O.C.M.E.</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>FEBRUARY 05, 1996</b>                                |   |
|  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>J. LARON LOCKE MD 111 Penn Street, Baltimore, Maryland 21201</b>  |  |   |   |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>FEB 07 1996</b>  |  |  | 32. Registrar's Signature<br><b>John Andrew Carroll</b>   |   |  |  |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

12-11-50

[Faint, mostly illegible text covering the main body of the page, possibly a letter or report.]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04925

|   |   |  |   |  |  |  |   |  |  |  |
|---|---|--|---|--|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner                       | 1. Decedent's Name (First, Middle, Last)<br>JULIA BALDWIN CONWAY  |  |   |  |  |  | 2. Date of Death<br>Month Day Year<br>FEBRUARY 1, 1996  |  | 3. Time of Death<br>6:00PM   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>3403 HEIDI LANE   |  |   |  |  |  | 4b. City, Town, or Location of Death<br>LANDOVER  |  | 4c. County of Death<br>PRINCE GEORGE'S   |  |
| Funeral<br>Director                                     | 5. Social Security Number<br>577-30-7602  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>68 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>MARCH 7, 1927  |  | 9. Birthplace (State or Foreign Country)<br>NORTH CAROLINA   |  |
|   | Usual Residence of Decedent   |  |   |  |  |  |   |  |  |  |
| To Be Completed by Funeral Director                     | 10a. State<br>MARYLAND  |  | 10b. County<br>PRINCE GEORGE'S  |  | 10c. City, Town or Location<br>LANDOVER  |  |   |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|   | 10e. Street and Number<br>2005 KENT VILLAGE DRIVE   |  |   |  | 10f. Zip Code<br>20785   |  | 10g. Citizen of What Country?<br>U.S.A.   |  |  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: BLACK |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8th College (1-4or 5+) TAX EXAMINER  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>TAX EXAMINER  |  |   | 16b. Kind of Business/Industry<br>GOVERNMENT                     |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>LEE BALDWIN  |  |   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>JULIA MERRITT  |  |  |  |
| To Be Completed by Physician/Medical Examiner           | 19a. Informant's Name/Relationship (Type, Print)<br>VICKY ROOKARD/DAUGHTER  |  |   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2005 KENT VILLAGE DR, LANDOVER, MD 20785   |  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>HARMONY MEMORIAL PARK   |  | Date<br>2/7/1996   |  | 20c. Location - City or Town, State<br>LANDOVER, MARYLAND   |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br><i>Indawana L. Braxton</i>   |  |   |  | 22. Name and Address of Facility<br>J.B. JENKINS FUNERAL HOME<br>7474 LANDOVER RD, LANDOVER, MD 20785  |  |   |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <i>Cancer of the lung</i><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of): |  |   |  |  |  |   |  |  |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |   |  |  |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner           | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |  |
|   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <i>Group Home</i> |  |  |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 28d. Describe how injury occurred  |  |
|   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
|   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |  |  |   |  |  |  |
| State Registrar   | 29b. Signature and title of certifier<br><i>Indawana L. Braxton M.D.</i>  |  |   |  |  |  | 29c. License number<br>226260   |  | 29d. Date signed (Month, Day, Year)<br>2/6/96  |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Fumikazu Kawakami, M.D., 1160 Varnum Street, NE, Washington, D.C. 20017   |  |   |  |  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br>FEB 07 1996        |   |  |   |  |  |  |   |  |  |  |
| 32. Registrar's Signature<br><i>John Andrew Randall</i> |   |  |   |  |  |  |   |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04926

|   |   |  |   |  |   |  |   |  |
|---|---|--|---|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Denise Marie Cooper</b>  |  |   |  | 2. Date of Death<br>Month <b>02</b> Day <b>02</b> Year <b>1996</b>  |  | 3. Time of Death<br><b>11:30PM</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Prince George's Hospital</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Cheverly</b>   |  | 4c. County of Death<br><b>Prince George's</b>   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>223-96-2295</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>39</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>04-11-1956</b>  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Washington, DC</b>   |  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Prince George's</b>   |  | 10c. City, Town or Location<br><b>Upper Marlboro</b>  |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>17208 Clairfield Lane</b>  |  | 10f. Zip Code<br><b>20772</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>   |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br><b>12th</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Secretary</b>   |  | 16b. Kind of Business/Industry<br><b>Government</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>Dave Barbour, Jr.</b>   |  |
|   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Harper</b>   |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Dave Barbour, Jr.</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>664 Madison St, NE, Washington, DC 20011</b>  |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                   |  |
| To Be Completed by Physician/Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>George Washington Cemetery</b>   |  | 20c. Location - City or Town, State<br><b>Adelphi, Maryland</b>   |  | 21. Signature of Funeral Service Licensee<br><b>Juanawana L. Braxton</b>  |  | 22. Name and Address of Facility<br><b>J. B. Jenkins Funeral Home<br/>7474 Landover Rd, Landover, MD 20785</b>  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. <b>FUNGAL SEPSIS WITH SEPTICAEMIA</b><br>Due to (or as a consequence of):<br>b. <b>DIC WITH COAGULOPATHY WITH SEPTICAEMIA</b><br>Due to (or as a consequence of):<br>c. <b>RESPIRATORY FAILURE DUE TO SEPSIS</b><br>Due to (or as a consequence of):<br>d. <b>BOWEL PERFORATION SPONTANEOUS</b> |  | Approximate Interval Between Onset and Death<br><b>19 day</b><br><b>19 day</b><br><b>18 day</b><br><b>ONE</b>   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| To Be Completed by Physician/Medical Examiner | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined |  |
|   | 28a. Date of Injury (Month, Day, Year)<br><b>28b. Time of Injury<br/>M</b><br><b>28c. Injury at Work?<br/>1 Yes 2 No</b><br><b>28d. Describe how injury occurred</b><br><b>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)</b><br><b>28f. Location (Street and Number or Rural Route Number, City or Town, State)</b>  |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><b>Sanjay S. Anand M.D.</b>  |  | 29c. License number<br><b>D-41023</b>   |  |
| State Registrar                               | 29d. Date signed (Month, Day, Year)<br><b>2/6/96</b>  |  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>SARAJIT S. ANAND 2 ST. PATRICK'S DRIVE #404 WALDORF MD-20705</b>   |  | 31. Date filed (Month, Day, Year)<br><b>FEB 07 1996</b>   |  | 32. Registrar's Signature<br><b>Judy Anderson</b>   |  |

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR   |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 96 04927  |  |   |  |  |  |
|--|--|--|--|--|--|--|--|---|--|---|--|--|--|
| CERTIFICATE OF DEATH   |  |  |  | REG. NO.   |  |  |  |   |  |   |  |  |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Mary Coleman</i>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><i>02 - 05 - 96</i>  |  |  |  | 3. TIME OF DEATH<br><i>446 P.M.</i>   |  |   |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br><i>421-38-8196</i>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><i>73</i> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS                               |  | IF UNDER 24 HRS.<br>HOURS MIN.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>04-16-1922</i> |  | 8. BIRTHPLACE (State or Foreign Country)<br><i>Alabama</i> |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>Laurel Regional Hospital</i>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Laurel</i>   |  |  |  | 9c. COUNTY OF DEATH<br><i>Prince George's</i>   |  |   |  |  |  |
| RESIDENCE OF DECEDENT  |  |  |  |  |  |  |  |   |  |   |  |  |  |
| 10a. STATE<br><i>MD</i>  |  | 10b. COUNTY<br><i>Prince George's</i>  |  | 10c. CITY, TOWN OR LOCATION<br><i>Seat Pleasant</i>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |   |  |  |  |
| 10e. STREET AND NUMBER<br><i>6313 Seat Pleasant Drive</i>  |  |  |  | 10f. ZIP CODE<br><i>20743</i>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  |   |  |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>Black</i>                         |  |   |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><i>7th</i>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>Housewife</i>            |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>Private</i>   |  |  |  |   |  |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Henry Blackmon</i>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Mattie Hutt</i>  |  |  |  |   |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Shirley Hamilton/Daughter</i>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>6313 Seat Pleasant Dr., Seat Pleasant, MD 20743</i>  |  |  |  |   |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>New Castle Cemetery 02/10/1996</i>                     |  |  |  | 20c. LOCATION — City or Town, State<br><i>New Castle, AL</i> |  |   |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Humbrey Bruscoe Tonic</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>J.B. JENKINS FUNERAL HOME 20785<br/>7474 Landover Rd, Landover, MD</i>  |  |  |  |   |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |  |  |  |  |   |  |   |  | Approximate Interval Between Onset and Death               |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cardiopulmonary Arrest</i>  |  |  |  |  |  |  |  |   |  |   |  |  |  |
| DUE TO OR AS A CONSEQUENCE OF:   |  |  |  |  |  |  |  |   |  |   |  |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  |  |  |  |  |  |  |   |  |   |  |  |  |
| a. <i>Renal Failure, Acute</i>   |  |  |  |  |  |  |  |   |  |   |  |  |  |
| b. <i>Sepsis</i>   |  |  |  |  |  |  |  |   |  |   |  |  |  |
| c. <i>Calcareous ulcer infected</i>  |  |  |  |  |  |  |  |   |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Insulin Dependent Diabetes Mellitus</i>   |  |  |  |  |  |  |  |   |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |   |  |   |  |  |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |  |  |  |  |  |   |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |   |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  |  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M                                     |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  | 28d. DESCRIBE HOW INJURY OCCURRED                           |  |  |  |
|  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                    |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Wayne Jones MD Attending</i>   |  |  |  | 29c. LICENSE NUMBER<br><i>D30111</i>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>2-6-96</i>        |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>11305 Pitsea Dr Beltsville Md 20705-1757</i>   |  |  |  |  |  |  |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><i>FEB 07 1996</i>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Andrew Raskell</i>  |  |  |  |   |  |   |  |  |  |

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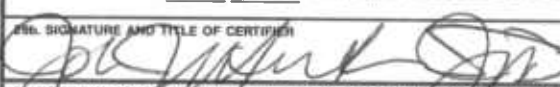

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. FOR STATE REGISTRAR  |  |   |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 96 04928  |  |  |  |
|---|--|---|--|--|--|--|--|---|--|--|--|
| 1. DECEASED'S NAME (First, Middle, Last)  |  |   |  | 2. DATE OF DEATH   |  |  |  | 3. TIME OF DEATH  |  |  |  |
| VICENTE R. CORRALES   |  |   |  | FEB 3 1996   |  |  |  | 11:15 P M   |  |  |  |
| 4. SOCIAL SECURITY NUMBER   |  | 5. SEX  |  | 6. AGE (In yrs. last birthday)   |  | 7. DATE OF BIRTH                               |  | 8. BIRTHPLACE (State or Foreign Country)  |  |  |  |
| 213-98-2090   |  | 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F            |  | 66 YRS.  |  | DEC. 29 1929                                   |  | NICARAGUA   |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH  |  |  |  | 9c. COUNTY OF DEATH   |  |  |  |
| ALLEGIS HEALTH CENTER-KENSINGTON  |  |   |  | KENSINGTON   |  |  |  | MONTGOMERY  |  |  |  |
| 10a. STATE  |  |   |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION                    |  | 10d. INSIDE CITY LIMITS?  |  |  |  |
| MD  |  |   |  | MONTGOMERY   |  | KENSINGTON                                     |  | <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO               |  |  |  |
| 10e. STREET AND NUMBER  |  |   |  | 10f. ZIP CODE  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?   |  |  |  |
| 3000 McCOMA DRIVE   |  |   |  | 20895  |  |  |  | NICARAGUA   |  |  |  |
| 11. MARITAL STATUS  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?                                     |  | 13. WAS DECEDENT OF HISPANIC ORIGIN?   |  | 14. RACE — American Indian, Black, White, etc. |  |   |  |  |  |
| 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married  |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO         |  | 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | Specify: HISPANIC                              |  |   |  |  |  |
| 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | IF YES, GIVE WAR OR DATES   |  | If yes, specify Cuban, Mexican, Puerto Rican, etc.)  |  | Specify:                                       |  |   |  |  |  |
| 15. DECEASED'S EDUCATION  |  |   |  | 16a. DECEASED'S USUAL OCCUPATION   |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |  |  |
| (Specify only highest grade completed)  |  |   |  | (Give kind of work done during most of working life. Do NOT use retired.)  |  |  |  |   |  |  |  |
| Elementary/Secondary (0-12) 6TH   |  |   |  | College (1-4 or 5+) College (1-4 or 5+)  |  |  |  | SHOEMAKER   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)  |  |  |  |   |  |  |  |
| DAVID CORRALES  |  |   |  | CANDIDA ACEVEDO  |  |  |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)                          |  |  |  |   |  |  |  |
| DAVID F. CORRALES   |  |   |  | 13469 DEMETRIAS WAY, GERMANTOWN, MD 20874  |  |  |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) |  | 20c. LOCATION — City or Town, State  |  |  |  |   |  |  |  |
| 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State   |  | FAMILY CEMETERY   |  | FEB 10-96  |  | MANAGUA, NICARAGUA                             |  |   |  |  |  |
| 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |   |  |  |  |  |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE   |  |   |  | 22. NAME AND ADDRESS OF FACILITY   |  |  |  |   |  |  |  |
|    |  |   |  | W.H. BACON FUNERAL HOME INC.   |  |  |  |   |  |  |  |
|   |  |   |  | 3447 14TH STREET, N.W. WASH., D.C. 20010   |  |  |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. |  |   |  |  |  |  |  | Approximate Interval Between Onset and Death  |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →   |  |   |  |  |  |  |  | DAYS  |  |  |  |
| a. ASPIRATION PNEUMONIA   |  |   |  |  |  |  |  |   |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |  |  |  |  |   |  |  |  |
| b. STROKE WITH IMPAIRED SWALLOWING  |  |   |  |  |  |  |  | YEARS   |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |  |  |  |  |   |  |  |  |
| c.  |  |   |  |  |  |  |  |   |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |  |  |  |  |   |  |  |  |
| d.  |  |   |  |  |  |  |  |   |  |  |  |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  |   |  |  |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  |  |  |   |  |  |  |
| HYPERTENSION  |  |   |  |  |  |  |  |   |  |  |  |
| DIABETES  |  |   |  |  |  |  |  |   |  |  |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |   |  |  |  |  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?  |  |   |  | 26. PLACE OF DEATH (Check only one)  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?  |  |  |  |
| 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |   |  | HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA |  |  |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO             |  |  |  |
| 27. MANNER OF DEATH   |  |   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  |  |  | 28b. TIME OF INJURY   |  |  |  |
| 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation  |  |   |  |  |  |  |  | M   |  |  |  |
| 2 <input type="checkbox"/> Accident   |  |   |  |  |  |  |  | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |
| 3 <input type="checkbox"/> Suicide  |  |   |  |  |  |  |  |   |  |  |  |
| 4 <input type="checkbox"/> Homicide   |  |   |  |  |  |  |  |   |  |  |  |
| 8 <input type="checkbox"/> Could not be determined  |  |   |  |  |  |  |  |   |  |  |  |
|   |  |   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                 |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)        |  |  |  |
|   |  |   |  |  |  |  |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)   |  |   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER  |  |  |  | 29c. LICENSE NUMBER   |  |  |  |
| 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                        |  |   |  |                                     |  |  |  | D36046  |  |  |  |
| 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  |  |  |  | 29d. DATE SIGNED (Month, Day, Year)   |  |  |  |
|   |  |   |  |  |  |  |  | 2/5/96  |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)  |  |   |  | 31. DATE FILED (Month, Day, Year)  |  |  |  | 32. REGISTRAR'S SIGNATURE   |  |  |  |
| 4701 Randolph Rd. #216 Rockville MD 20852   |  |   |  | FEB 05 1996  |  |  |  |  |  |  |  |

080/17 24

080/17 24

Amended # 590, + 106, P.C. 8C, 2/16/96

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04929

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Mabel Campbell</i>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><i>January 17, 1996</i>   |  | 3. TIME OF DEATH<br>HOURS MIN.<br><i>11:54</i>  |  |
| 4. SOCIAL SECURITY NUMBER<br>409-18-2167   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>76 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>March 31, 1919  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Md.  |  | 9a. FACILITY NAME (If not Institution, give street and number)<br>4711 Berwyn House Road   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>College Park   |  | 9c. COUNTY OF DEATH<br>Montgomery   |  |
| 10a. STATE<br>Md.  |  | 10b. COUNTY<br>Montgomery  |  | 10c. CITY, TOWN OR LOCATION<br>College Park   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br>4711 Berwyn House Road   |  |  |  | 10f. ZIP CODE<br>20740  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>United States  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Secretary   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Secretarial   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Unknown   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Unknown  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Delphine Barksdale   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>8125 48th Ave. #620 College Park, Md 20740   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>No. Virginia Crematory 1-2-96   |  | 20c. LOCATION — City or Town, State<br>Arlington, VA  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Sharon Johnson-Salley</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Capitol Mortuary<br>1425 Maryland Ave., NE Wash., DC  |  |   |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Arteriosclerotic cardiovascular disease</i><br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 28d. DESCRIBE HOW INJURY OCCURED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Augusta P. Poonjag</i>   |  |  |  | 29c. LICENSE NUMBER<br>A21230   |  | 29d. DATE SIGNED (Month, Day, Year)<br>January 17, 1996   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>Augusta P. Poonjag MD, 5009 Rayburn Ct. Cp Spn. Md 20748</i>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>FEB 06 1996   |  | 32. REGISTRAR'S SIGNATURE<br><i>John A. ...</i>  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

050 28

050 28



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04930

|  |   |  |   |   |   |  |   |
|--|---|--|---|---|---|--|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>WALTER MAURICE CLIFFORD 3rd   |  |   | 2. Date of Death<br>Month JAN Day 08 Year 1996  |   | 3. Time of Death<br>8:46 P   |   |
|  | 4a. Facility Name (If not institution, give street and number)<br>PRINCE GEORGES HOSPITAL   |  |   | 4b. City, Town, or Location of Death<br>CHEVERLY  |   | 4c. County of Death<br>PRINCE GEORGES  |   |
| Funeral<br>Director  | 5. Social Security Number<br>579-98-6775  |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>29 Yrs.   | 8. Date of Birth (Month, Day, Year)<br>10-21-66   |  | 9. Birthplace (State or Foreign Country)<br>Wash., D.C.         |
|  | Usual Residence of Decedent   |  |   |   |   |  |   |
| To Be Completed by Funeral Director  | 10a. State<br>MD.   | 10b. County<br>Prince Georges  | 10c. City, Town or Location<br>Adelphi  |   |   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |   |
|  | 10e. Street and Number<br>9708 23rd Avenue  |  |   | 10f. Zip Code<br>20783-1303   |   | 10g. Citizen of What Country?<br>USA   |   |
|  | 11. Marital Status<br>X <input checked="" type="checkbox"/> Navar Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: BLK. |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12th  |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>student                    |   | 16b. Kind of Business/Industry<br>N/A  |   |
|  | 17. Father's Name (First, Middle, Last)<br>Walter Maurice Clifford Jr.  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Diane Sutton   |   |  |   |
| Physician<br>/Medical<br>Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br>Walter M. Clifford Jr.  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>9708 23rd Ave., Adelphi MD. 20783-1303 |   |  |   |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>George Washington   |   | Date<br>1-18-96   | 20c. Location - City or Town, State<br>Adelphi Md.   |   |
|  | 21. Signature of Funeral Service Licensee<br>Sarah Branch #915  |  |   | 22. Name and Address of Facility<br>B.K. HENRY Funeral Home Chapel, Inc.<br>420 - H STREET N.E. WASH., D.C. 20002                       |   |  |   |
|  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. Multiple Gun Shot Wounds<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |  |   |   |   |  |   |
|  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |   |   |   |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |  |   |   | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |  |   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide  |   | 28a. Date of Injury (Month, Day Year)<br>1-8-96  |   | 28b. Time of Injury<br>2045 M   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No    |   |
| 28d. Describe how injury occurred<br>subject shot  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>street |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>7909 14th Ave Hyattsville                               |   |  |   |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |   |   |   |  |   |
| 29b. Signature and title of certifier<br>[Signature]   |   |  | 29c. License number<br>O.C.M.E  |   | 29d. Date signed (Month, Day, Year)<br>JANUARY 10, 1996   |  |   |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>David R. Fowler 111 Penn Street, Baltimore, Maryland 21201   |   |  |   |   |   |  |   |
| 31. Date filed (Month, Day, Year)<br>FEB 09 1996   |   |  |   |   |   |  |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

...and the ...

*Data Entry*

VOID  
CERTIFICATE 88

96-04931

SEE  
CERTIFICATE 88

-----



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 96 04932

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Margery Mead Cain

2. Date of Death

February 5, 1996

Day Year

3. Time of Death

2:15 pm

4a. Facility Name (If not institution, give street and number)

8921 Burdette Rd.

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

231-64-0386

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

77

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

July 19, 1918

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8921 Burdette Rd.

10f. Zip Code

20187

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Arthur B. Mead

18. Mother's Name (First, Middle, Maiden Surname)

Elma Senken

19a. Informant's Name/Relationship (Type, Print)

Mead Taylor Cain

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

30 East 68th Street #7A New York, NY 10021

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arlington National Cem.

Date

2-13-96

20c. Location - City or Town, State

Arlington, Virginia

21. Signature of Funeral Service Licensee

M00956

22. Name and Address of Facility

Joseph Gawler's Sons, Inc.  
5130 Wisconsin Avenue, NW  
Washington, D.C. 20016

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Bronchogenic Carcinoma

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 Months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D27465

29d. Date signed (Month, Day, Year)

February 5, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert Langevin, M.D., 5454 Wisconsin Avenue, Ste. #1125, Bethesda, Maryland

20815

31. Date filed (Month, Day, Year)

FEB 07 1996

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 96 01933  
 2. Date of Death Month Day Year JAN. 28, 1996  
 3. Time of Death 1:59 P.M.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)  
 ELIZABETH MARLOW CONNELL

4a. Facility Name (If not Institution, give street and number)  
 SUBURBAN HOSPITAL

4b. City, Town, or Location of Death BETHESDA  
 4c. County of Death MONTGOMERY

Funeral  
Director

5. Social Security Number 253-72-9187  
 6. Sex 1 ☐ M 2 ☐ F  
 7. Age (In yrs. last birthday) 85 Yrs.  
 8. Date of Birth (Month, Day, Year) DEC. 13, 1910  
 9. Birthplace (State or Foreign Country) WASHINGTON, DC

Usual Residence of Decedent

10a. State MARYLAND  
 10b. County MONTGOMERY  
 10c. City, Town or Location CHEVY CHASE  
 10d. Inside City Limits 1 ☐ Yes 2 ☒ No

10e. Street and Number 3732 MANOR ROAD  
 10f. Zip Code 20815  
 10g. Citizen of What Country? U.S.A.

11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced  
 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No  
 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:  
 14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)  
 Elementary/Secondary (0-12) 12 College (1-4or 5+)  
 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER  
 16b. Kind of Business/Industry OWN HOME

17. Father's Name (First, Middle, Last) WILLIAM MARLOW  
 18. Mother's Name (First, Middle, Maiden Surname) CLARA KRAKHARDT

19a. Informant's Name/Relationship (Type, Print) ELIZABETH B. RYNEX, NIECE  
 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4624 WINDON PL. N.W. WASHINGTON, D.C. 20016

20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)  
 20b. Place of Disposition (Name of cemetery, crematory or other place) ROCK CREEK CEMETERY  
 Date 2/2/96  
 20c. Location - City or Town, State WASHINGTON, D.C.

21. Signature of Funeral Service Licensee  
 22. Name and Address of Facility JOSEPH GAWLER'S SONS, INC 5130 WISCONSIN AVE. N.W., WASHINGTON, D.C. 20016

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  
 Immediate Cause (Final disease or condition resulting in death)  
 Approximate Interval Between Onset and Death

a. Myocardial Failure  
 Due to (or as a consequence of):  
 b. Arteriosclerosis  
 Due to (or as a consequence of):  
 c.  
 Due to (or as a consequence of):  
 d.  
 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atrial Fibrillation

23b. Did tobacco use contribute to the cause of death?  
 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No  
 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?  
 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)  
 Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined  
 28a. Date of Injury (Month, Day Year) Nov  
 28b. Time of Injury M  
 28c. Injury at Work? 1 ☐ Yes 2 ☐ No  
 28d. Describe how injury occurred  
 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  
 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print) John B. Umhau MD 8805 Conn. Ave. Chevy Chase, MD

31. Data filed (Month, Day, Year) FEB 07 1996  
 32. Registrar's Signature John Umhau

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 96 04934

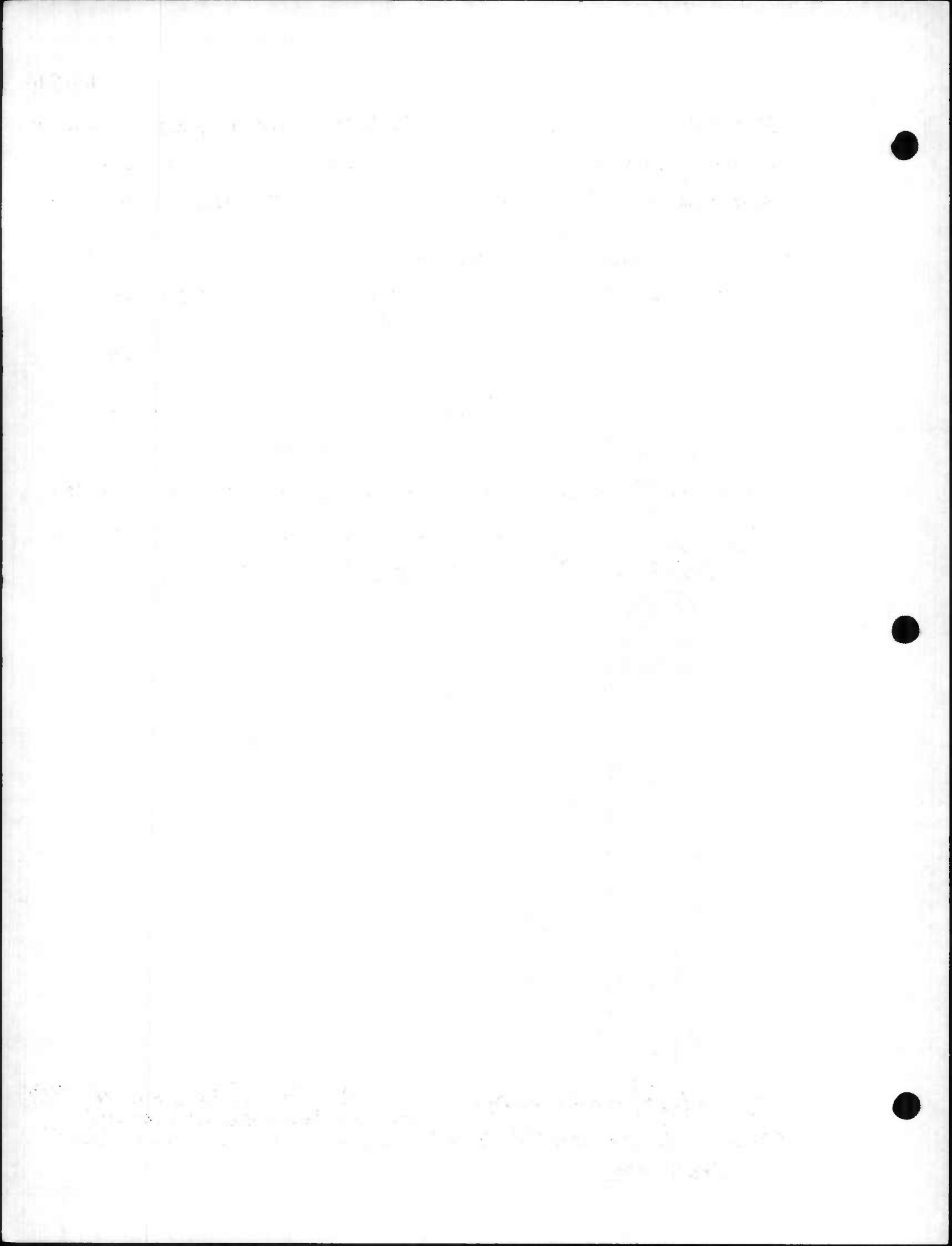
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|--|--|--|---|--|---|---|---|--|---|--|
| <b>Physician<br/>/Medical<br/>Examiner</b>   | 1. Decedent's Name (First, Middle, Last)<br><b>Snirley M. Coleman</b>                      |  |   |  |   | 2. Date of Death<br>Month <b>February</b> Day <b>2</b> Year <b>1996</b>   |   | 3. Time of Death<br><b>10:00am</b>   |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Suburban Hospital</b> |  |   |  |   | 4b. City, Town, or Location of Death<br><b>Bethesda</b>   |   | 4c. County of Death<br><b>Montgomery</b>   |   |  |
| <b>Funeral<br/>Director</b>  | 5. Social Security Number<br><b>049-24-8034</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>67</b> Yrs.  |   | 8. Date of Birth (Month, Day, Year)<br><b>Mar. 15, 1928</b>                                 |  | 9. Birthplace (State or Foreign Country)<br><b>Connecticut</b>          |  |
|  | Usual Residence of Decedent  |  |   |  |   |   |   |  |   |  |
| 10a. State<br><b>Maryland</b>  |  |  | 10b. County<br><b>Montgomery</b>  |  | 10c. City, Town or Location<br><b>Gaithersburg</b>  |   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |  |
| 10e. Street and Number<br><b>18313 Gardenia Way</b>  |  |  |   |  | 10f. Zip Code<br><b>20879</b>   |   |   | 10g. Citizen of What Country?<br><b>United States</b>  |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b> |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> Collage (1-4or 5+) <b>Clerk</b>   |  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Clerk</b>   |   |   | 16b. Kind of Business/Industry<br><b>U.S. Government</b>                                       |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Harold W. Black</b>  |  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Helen Taylor</b>  |   |   |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Julius R. Coleman, husband</b>  |  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>18313 Gardenia Way, Gaithersburg, Maryland 20879</b>  |   |   |  |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Gate of Heaven Cemetery</b>  |  |   | 20c. Location - City or Town, State<br><b>2/10/96 Silver Spring, Md.</b>  |   |  |   |  |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |  |  |   |  | 22. Name and Address of Facility<br><b>McGuire Funeral Service, Inc.<br/>7400 Georgia Ave. N.W., Washington, D.C.</b>   |   |   |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>a. <b>GRAM POSITIVE SEPSIS</b><br/>Due to (or as a consequence of):</p> <p>b. <b>BACTERIAL PNEUMONIA</b><br/>Due to (or as a consequence of):</p> <p>c. <b>METASTATIC NONSMALL CELL LUNG CANCER</b><br/>Due to (or as a consequence of):</p> <p>d. _____</p> </div> <div style="width: 35%; text-align: right;"> <p><b>ONE WEEK</b></p> <p><b>ONE WEEK</b></p> <p><b>THREE MONTHS</b></p> </div> </div> |  |  |   |  |   |   |   |  |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |  |   |  |   |   |   |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how Injury occurred                                       |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |   |  |   |   |   |  |   |  |
| 29b. Signature and title of certifier<br><i>[Signature]</i>  |  |  |   |  | 29c. License number<br><b>D37236</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>FEBRUARY 02 1996</b>                              |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>CAROLYN HENDRICKS MD 9707 MEDICAL CENTER DRIVE 20850</b>  |  |  |   |  |   |   |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 07 1996</b>  |  |  |   |  | 32. Registrar's Signature<br><i>[Signature]</i>   |   |   |  |   |  |

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR



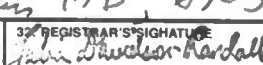
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04935

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>DEBORAH COHEN</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>FEB. 1, 1996</b>  |  | 3. TIME OF DEATH<br><b>6:30 A M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>137-32-0017</b>   |  | 5. SEX<br><b>1 M 2 F</b>  |  | 8. AGE (In yrs. last birthday)<br><b>86</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>NOV. 16, 1909</b>                                      |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>THE HEBREW HOME</b>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>ROCKVILLE</b>  |  | 9c. COUNTY OF DEATH<br><b>MONTGOMERY</b>   |  |
| 10a. STATE<br><b>MD.</b>  |  | 10b. COUNTY<br><b>MONTGOMERY</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>ROCKVILLE</b>  |  | 10d. INSIDE CITY LIMITS?<br><b>1 YES 2 NO</b>  |  |
| 10e. STREET AND NUMBER<br><b>6121 MONTROSE RD.</b>  |  |   |  | 10f. ZIP CODE<br><b>20852</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 11. MARITAL STATUS<br><b>3 Widowed 4 Divorced</b>   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 YES 2 NO</b><br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 YES 2 NO</b> Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                          |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br><b>5+</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>SOCIAL WORKER</b>                      |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>PRIVATE</b>   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>UNKNOWN LEVY</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>UNKNOWN</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>RICHARD H. CONANT</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9301 INGLEWOOD CT., POTOMAC, MD. 20854</b> |  |  |  |
| 20a. METHOD OF DISPOSITION<br><b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>CHAMBERS CREMATORY</b>  |  | DATE<br><b>2/4</b>   |  | 20c. LOCATION — City or Town, State<br><b>RIVERDALE, MD.</b>                                     |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br> <b>MO0091</b>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>W. W. CHAMBERS CO., RIVERDALE, MD. 20737</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Urinary tract infection</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>Malnutrition</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>Alzheimer's dementia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Approximate Interval Between Onset and Death<br><b>9 days</b><br><b>Months</b><br><b>Years</b> |  |   |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><b>1 YES 2 NO</b>  |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>   |  |   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1 YES 2 NO</b> |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1 YES 2 NO</b>   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b><br>OTHER: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b> |  |  |  |  |  |
| 27. MANNER OF DEATH<br><b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</b>   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br><b>1 YES 2 NO</b>  |  |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)                     |  |
| 29a. CERTIFIER (Check only one)<br><b>1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b><br><b>2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br> <b>MD</b>                  |  |  |  |  |  |
|   |  | 29c. LICENSE NUMBER<br><b>D 23958</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>2/1/96</b>   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Burd I. Feldman MD, 6105 Montrose Rd., Rockville, MD 20852</b>  |  |   |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 05 1996</b>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br>                               |  |  |  |

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State of Maryland / Department of Health and Mental Hygiene

Amended # 29d per Dr., 2/12/96, MRT, Montg. City

Certificate of Death

Reg. No. 96 04936

Physician  
/Medical  
Examiner

Funeral  
Director

|   |  |   |  |   |  |   |  |  |  |  |  |   |  |
|---|--|---|--|---|--|---|--|--|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br>Joseph Elmer Cadell   |  |   |  | 2. Date of Death<br>Month February Day 3, Year 1996   |  |   |  | 3. Time of Death<br>2:28 PM  |  |  |  |   |  |
| 4a. Facility Name (If not institution, give street and number)<br>Montgomery General Hospital   |  |   |  | 4b. City, Town, or Location of Death<br>Olney   |  |   |  | 4c. County of Death<br>Montgomery  |  |  |  |   |  |
| 5. Social Security Number<br>578-05-1757  |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>78 Yrs.   |  | If Under 1 Year<br>Months Days  |  | If Under 24 Hrs.<br>Hours Min.   |  | 8. Date of Birth<br>(Month, Day, Year)<br>December 14, 1917                                      |  | 9. Birthplace (State or Foreign Country)<br>Washington DC |  |
| Usual Residence of Decedent   |  |   |  |   |  |   |  |  |  |  |  |   |  |
| 10a. State<br>Maryland  |  | 10b. County<br>Montgomery   |  | 10c. City, Town or Location<br>Silver Spring  |  |   |  |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |   |  |
| 10e. Street and Number<br>7 Finsbury Park Court   |  |   |  | 10f. Zip Code<br>20906  |  |   |  | 10g. Citizen of What Country?<br>United States                                       |  |  |  |   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: WW II |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                     |  |  |  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Maritime Administration  |  |   |  | 16b. Kind of Business/Industry<br>U S Government                                     |  |  |  |   |  |
| 17. Father's Name (First, Middle, Last)<br>Joseph Edward Cadell   |  |   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Nellie Garrett   |  |  |  |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Nelly Cadell  |  |   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>7 Finsbury Park Ct., Silver Spring, MD 20906 |  |  |  |  |  |   |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Cedar Hill Cemetery   |  |   |  | Date<br>2-7-96   |  | 20c. Location - City or Town, State<br>Suitland, MD  |  |   |  |
| 21. Signature of Funeral Service Licensee<br>▶ Alan J. Donnell  |  |   |  |   |  | 22. Name and Address of Facility<br>Hines-Rinaldi Funeral Home<br>11800 New Hampshire Ave., Silver Spring, MD 20904                           |  |  |  |  |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. Pneumonia<br>Due to (or as a consequence of):<br>b. Chronic Obstructive Pulmonary Disease<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br><br>Approximate Interval Between Onset and Death<br>2 weeks<br>13 years |  |   |  |   |  |   |  |  |  |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Acute Renal Insufficiency<br>Cor pulmonale  |  |   |  |   |  |   |  |  |  |  |  |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |   |  |   |  |   |  |  |  |  |  |   |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |  |  |  |  |  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |  |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  |   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |  |  |  |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  | 29b. Signature and title of certifier<br>▶ James A. Rossi MD  |  |   |  | 29c. License number<br>D 24543   |  | 29d. Date signed (Month, Day, Year)<br>February 3, 1996  |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>James A. Rossi MD, 3305 NORTH LEISUM WIND BLVD, SILVER SPRING MD 20906  |  |   |  |   |  |   |  |  |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br>FEB 06 1996  |  |   |  | 32. Registrar's Signature<br>John A. Rossi  |  |   |  |  |  |  |  |   |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

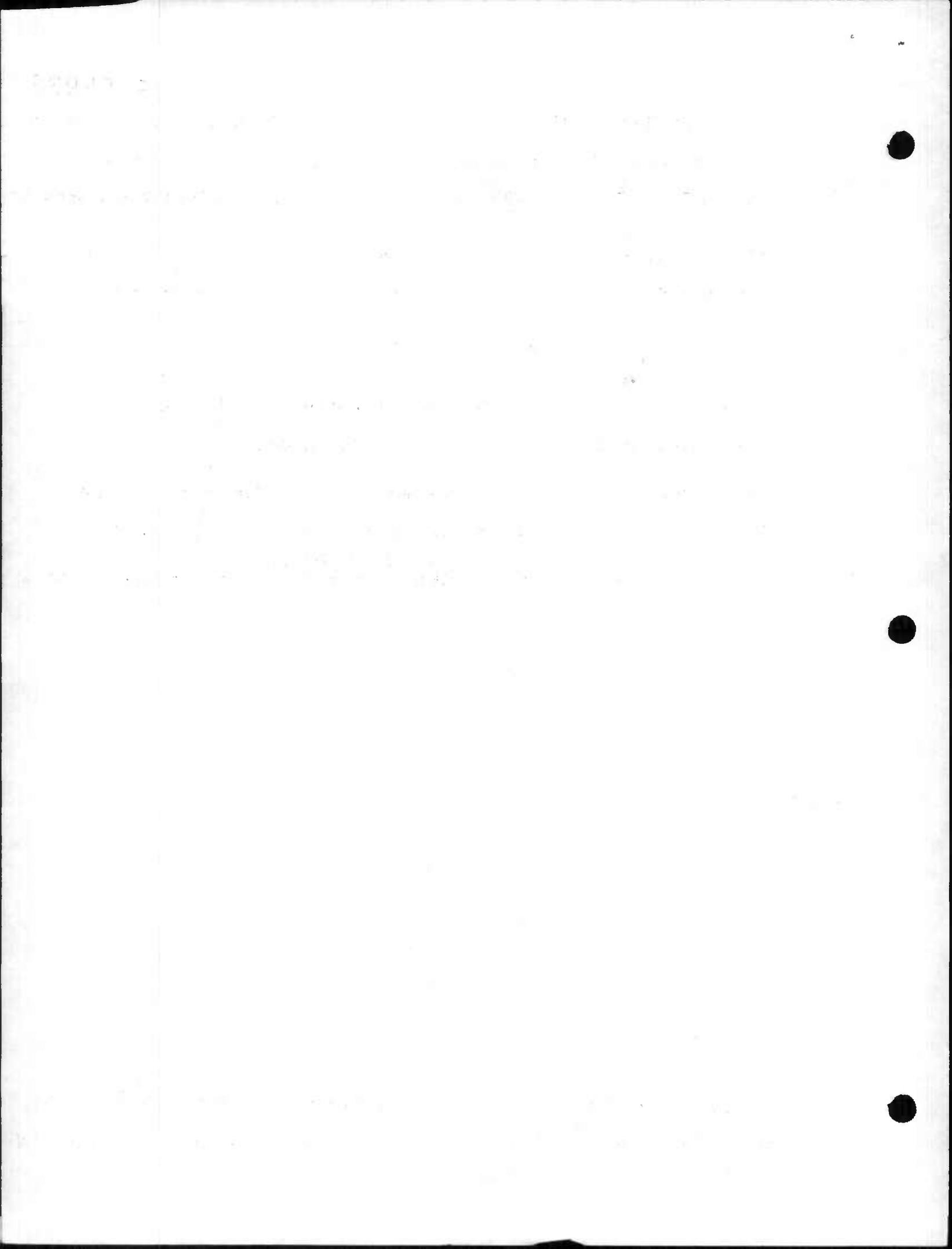
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Amended # 18, 2/15/96, N.D.S., Allegany Co.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04937

|  |  |  |  |  |  |  |  |   |  |   |  |   |  |   |  |
|--|--|--|--|--|--|--|--|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ANNE PEYTON DOUB</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>FEB. 11, 1996</b>   |  |  |  | 3. TIME OF DEATH<br><b>8:00 P. M.</b>   |  |   |  |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216-22-2601</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>90</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>July 30, 1905</b> |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>MARYLAND</b>   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>GOLDEN AGE GUEST HOME</b>   |  |  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>SYKESVILLE</b>   |  |   |  | 9c. COUNTY OF DEATH<br><b>CARROLL</b>                       |  |   |  |   |  |
| RESIDENCE OF DECEDENT  |  |  |  |  |  |  |  |   |  |   |  |   |  |   |  |
| 10a. STATE<br><b>MARYLAND</b>  |  |  |  | 10b. COUNTY<br><b>CARROLL</b>  |  |  |  | 10c. CITY, TOWN OR LOCATION<br><b>SYKESVILLE</b>  |  |   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO       |  |   |  |
| 10e. STREET AND NUMBER<br><b>1442 BUCKHORN ROAD</b>  |  |  |  |  |  | 10f. ZIP CODE<br><b>21784</b>  |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>              |  |   |  |   |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  |  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                               |  |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>NONE</b>   |  |  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>NONE</b>                            |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>NONE</b>               |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>ALBERT A. DOUB</b>   |  |  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>ANNE PEYTON COOK</b>   |  |   |  |   |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>ELIZABETH DOUB GLASGOW</b>  |  |  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8101 CONNECTICUT AVE., CHEVY CHASE, MD 20815</b> |  |   |  |   |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>ROSE HILL CEMETERY 2/16/96</b>   |  |  |  | 20c. LOCATION — City or Town, State<br><b>CUMBERLAND, MD</b>  |  |   |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Mandy G. Upchurch</i>  |  |  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>GEORGE-UPCHURCH FUNERAL HOME, P.A.<br/>202 GREENE ST., CUMBERLAND, MD 21502</b>                               |  |   |  |   |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b><br><b>a. Arteriosclerotic Cardiovascular Disease</b><br><b>b. Dementia</b><br><b>c. _____</b><br><b>d. _____</b><br><b>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> |  |  |  |  |  |  |  |   |  |   |  | Approximate interval Between Onset and Death<br><b>10 yrs.</b><br><b>10 yrs.</b>                      |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>   |  |  |  |  |  |  |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |   |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED                           |  |   |  |   |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  |  |  | 28i. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |  |  |   |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Patrick A. Turnes, M.D.</i>  |  |  |  |  |  | 29c. LICENSE NUMBER<br><b>D20806</b>   |  |   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>Feb. 12, 1996</b> |  |   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Patrick A. Turnes, M.D.-1425 Liberty Rd., Eldersburg, MD 21784</b>   |  |  |  |  |  |  |  |   |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 15 1996</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Judi Anderson-Randall</i>  |  |  |  |   |  |   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1980-81

11



1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

96 04938

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MELVIN LEROY DEAL, SR.</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>FEB. 10, 1996</b>   |  | 3. TIME OF DEATH<br><b>4:10 P M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>184-14-8395</b>  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>74</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>JAN 3, 1922</b>                            |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>PENNSYLVANIA</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>SACRED HEART HOSPITAL</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>CUMBERLAND</b>                             |  |
| 9c. COUNTY OF DEATH<br><b>ALLEGANY</b>   |  |  |  | 10a. STATE<br><b>PA</b>  |  | 10b. COUNTY<br><b>SOMERSET</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>MEYERSDALE</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>RT 3, BOX 75-A</b>                                      |  |
| 10f. ZIP CODE<br><b>15552</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WW 2</b>  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>           |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (9-12) <b>8</b> College (1-4 or 5+) <b>College</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>SHEET METAL WORKER</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>ALLEGANY BALLISTICS</b>   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>WILLIAM DEAL</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>MARY A. BAER</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>BERNICE M. DEAL</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>RT 3, BOX 75-A, MEYERSDALE, PA 15552</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Greenville Cem. Feb. 14, 96</b>  |  | 20c. LOCATION — City or Town, State<br><b>Meyersdale, PA</b>   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Newman Funeral Home, Inc.<br/>101 S. Grant St., Salisbury, PA 15558</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>CARDIOMYOPATHY</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Approximate Interval Between Onset and Death: <b>3 YRS</b><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. <b>BRAIN TUMOR</b><br>DUE TO (OR AS A CONSEQUENCE OF): <b>3 YRS</b><br>c. <b>SEIZURES</b><br>DUE TO (OR AS A CONSEQUENCE OF): <b>6 MONS</b><br>d. |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>  |  |  |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>  |  |  |  | 29c. LICENSE NUMBER<br><b>D36766</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>FEB 13, 1996</b>                           |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Vik Poonai, M.D., 955 Frederick St., Cumberland, MD 21502</b>  |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 14 1996</b>  |  | 32. REGISTRAR'S SIGNATURE<br>  |  |  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

02940 20

96 04939

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |   |
|--|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>EDNA VIRGINIA DAWSON   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>February 11 1996  |  | 3. TIME OF DEATH<br>6:08 P M   |   |
| 4. SOCIAL SECURITY NUMBER<br>218-16-3635   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>70 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>OCT 31 1925                                   |   |
| 8. BIRTHPLACE (State or Foreign Country)<br>MARYLAND   |  |  |  | 9. COUNTY OF DEATH<br>ALLEGANY  |  |  |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br>MEMORIAL HOSPITAL  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>CUMBERLAND   |  | 9c. COUNTY OF DEATH<br>ALLEGANY  |   |
| 10a. STATE<br>MARYLAND   |  |  |  | 10b. COUNTY<br>ALLEGANY   |  | 10c. CITY, TOWN OR LOCATION<br>CUMBERLAND  |   |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  |   |  |  |   |
| 10e. STREET AND NUMBER<br>414 GOETHE STREET  |  |  |  | 10f. ZIP CODE<br>21502  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: WHITE                     |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 7<br>College (1-4 or 5+)  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>HOUSE KEEPER   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>HOUSE KEEPER  |  |  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>GEORGE WASHINGTON HUGHES  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>EMMA DAVIS   |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>LINDA CHANEY   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>414 GOETHE STREET CYNBERLAND MARYLAND 21502  |  |  |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>REST LAWN CEMETERY FEB 14 1996  |  | 20c. LOCATION — City or Town, State<br>CUMBERLAND MARYLAND  |  |  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Dale L. Merritt</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>MERRITT-ADAMS FUNERAL HOME<br>404 DECATUR STREET CUMBERLAND MARYLAND  |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Sepsis<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |  | Approximate interval Between Onset and Death<br>2 weeks   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Pneumonia  |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>  |  |  |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |   |
|  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>J. Johnson</i>   |  |  |  | 29c. LICENSE NUMBER<br>D 33280  |  | 29d. DATE SIGNED (Month, Day, Year)<br>Feb. 12, 1996                                 |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Sunil Gupta M.D. Johnson Heights Medical Bldg. Suite 101 Cumberland MD 21502  |  |  |  |   |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br>FEB 12 1996   |  | 32. REGISTRAR'S SIGNATURE<br><i>J. Johnson</i>   |  |   |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04940

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

|   |  |  |  |   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Frederick Leonard Deal</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>February 6, 1996</b>   |  |  |  | 3. TIME OF DEATH<br><b>4:00 a m</b>   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>280-30-5191</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>61</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>June 7, 1934</b>                       |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>302 N. Main St.</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Accident</b>  |  |  |  | 9c. COUNTY OF DEATH<br><b>Garrett</b>   |  |   |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Garrett</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Accident</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO       |  |   |  |
| 10e. STREET AND NUMBER<br><b>302 N. Main St.</b>  |  |  |  | 10f. ZIP CODE<br><b>21520</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                      |  |   |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>white</b>       |  |   |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>11 th</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Plumber</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Plumbing</b>   |  |  |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Leslie Leonard Deal</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Elsie Bowser</b>  |  |  |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Beverly S. Deal</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>302 N. Main St., P.O. Box 212, Accident, MD 21520</b>                                       |  |  |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Newark Mem. Gardens, Feb. 9, 1996</b>  |  | 20c. LOCATION — City or Town, State<br><b>Newark, Ohio</b>  |  |  |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Newman Funeral Homes, P.A., P.O. Box 275<br/>179 Miller St., Grantsville, MD 21536</b>   |  |  |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiac Myopathy</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>a. <b>Uremia with dialysis</b><br>b. <b>Diabetes Mellitus</b><br>c. <b>Peripheral vascular disease</b><br>d. <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b> |  |  |  |   |  |  |  | Approximate Interval Between Onset and Death<br><b>6 months</b><br><b>3 years</b><br><b>20 years</b>  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Peripheral vascular disease</b>  |  |  |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><br><b>Herbert H. Leighton, M.D.</b>                                |  |  |  | 29c. LICENSE NUMBER<br><b>D 05658</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>February 6, 1996</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Herbert H. Leighton, M.D., 502 E. Oak Street, Oakland, Maryland 21550</b>   |  |  |  |   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 09 1996</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>  |  |  |  |   |  |   |  |

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THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR  |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 96 04941  |  |   |  |   |  |
|--|--|--|--|--|--|--|--|---|--|---|--|---|--|
| CERTIFICATE OF DEATH   |  |  |  | REG. NO.   |  |  |  |   |  |   |  |   |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br>GARY G. DAWSON   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>February 1 1996  |  |  |  | 3. TIME OF DEATH<br>5:38 P M  |  |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br>234-96-4899   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>39 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>Sept 26 1956  |  | 8. BIRTHPLACE (State or Foreign Country)<br>West Virginia |  |
| 9a. FACILITY NAME (If not Institution, give street and number)<br>Memorial Hospital  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Cumberland  |  |  |  | 9c. COUNTY OF DEATH<br>Allegany   |  |   |  |   |  |
| RESIDENCE OF DECEDENT  |  |  |  |  |  |  |  |   |  |   |  |   |  |
| 10a. STATE<br>West Virginia  |  | 10b. COUNTY<br>Mineral   |  | 10c. CITY, TOWN OR LOCATION<br>Piedmont  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO       |  |   |  |   |  |
| 10e. STREET AND NUMBER<br>76 Paxton St.  |  |  |  | 10f. ZIP CODE<br>26750   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>United States  |  |   |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                                      |  |   |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) Unknown<br>College (1-4 or 5+) College   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>None  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>None  |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Gary G. Dawson Sr.  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Louise Braithwaite  |  |  |  |   |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Louise Dawson  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>76 Paxton St. Piedmont, WV. 26750   |  |  |  |   |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Philos Cemetery 2-5-96                                    |  | DATE<br>2-5-96   |  | 20c. LOCATION — City or Town, State<br>Westernport, Md.                          |  |   |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Wayne Boal  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Boal Funeral Home<br>111 Church St. Westernport, Md.   |  |  |  |   |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ACUTE UPPER GI BLEED<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. ESOPHAGEAL VARICES<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. CIRRHOSIS OF LIVER<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |  |  |  |  | Approximate Interval Between Onset and Death<br>10 MIN<br>1 WEEKS<br>2 YEARS                          |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>ALCOHOLIC ABUSE  |  |  |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>  |  |  |  |  |  |  |  |   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |   |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Robert Orlino   |  |  |  | 29c. LICENSE NUMBER<br>D34846   |  | 29d. DATE SIGNED (Month, Day, Year)<br>February 3, 1996   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Robert Orlino M.D. 902 Seton Dr. Cumberland, Md. 21502  |  |  |  |  |  |  |  |   |  |   |  |   |  |
| 31. DATE FILED<br>FEB 07 1996  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>John A. ...   |  |  |  |   |  |   |  |   |  |

1210-1211





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR  |  |   |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 96 04942  |  |   |  |  |  |
|---|--|---|--|---|--|---|--|---|--|---|--|--|--|
| CERTIFICATE OF DEATH  |  |   |  | REG. NO.  |  |   |  |   |  |   |  |  |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>WILLIAM ARTHUR DOUGLAS</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH <b>FEB</b> DAY <b>4</b> YEAR <b>1996</b>  |  |   |  | 3. TIME OF DEATH<br><b>11:00AM</b>                      |  |   |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>288-18-0009</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>73</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Aug. 23, 1922</b>                              |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Ohio</b> |  |   |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>36 Great Oaks Drive</b>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Aberdeen</b>  |  |   |  | 9c. COUNTY OF DEATH<br><b>Harford</b>                   |  |   |  |  |  |
| 10a. STATE<br><b>MD</b>   |  |   |  | 10b. COUNTY<br><b>HARFORD</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>ABERDEEN</b>  |  |   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO       |  |  |  |
| 10e. STREET AND NUMBER<br><b>36 GREAT OAK DR</b>  |  |   |  | 10f. ZIP CODE<br><b>21001</b>   |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?                           |  |   |  |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WW II &amp; Korea</b>   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                  |  |   |  |   |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>  |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>U.S. Government</b>   |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>U.S. Army</b>      |  |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Alfred Douglas</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Elizabeth Hardwick</b>  |  |   |  |   |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Jacqueline Lix</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>150 Clare Ave., Hyde Park, Mass. 02136</b>  |  |   |  |   |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>R. A. Ferris &amp; Co., Inc. 2/6</b>  |  | 20c. LOCATION — City or Town, State<br><b>West Chester, PA</b>  |  |   |  |   |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Kirsten Byunglee</b>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Tarring-Cargo Funeral Home, P.A.<br/>Aberdeen, Maryland 21001-3399</b>   |  |   |  |   |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b><br><b>a. GUN SHOT WOUND HEAD</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. SELF INFLICTED</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d.</b><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |   |  |   |  |   |  |   |  | Approximate Interval Between Onset and Death  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>SIP CABSG HYPERTENSION</b><br><b>DIABETES MELLITUS</b><br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>  |  |   |  |   |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |   |  |   |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURED                        |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>DME</b>   |  |   |  | 29c. LICENSE NUMBER<br><b>OCME</b>                      |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>FEB 4 1996</b>  |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>G.S. PRABHU 1810 BELAND #102 FALLSTON MD 21047 879-6564</b>   |  |   |  |   |  |   |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 5 1996</b>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><b>John Andrew Roberts</b>   |  |   |  |   |  |   |  |  |  |

SENO 20

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR   |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 96 04943  |  |   |  |
|--|--|--|--|---|--|--|--|---|--|---|--|
| CERTIFICATE OF DEATH   |  |  |  | REG. NO.  |  |  |  |   |  |   |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>PARKER DAVIS</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JANUARY 28 1996</b>  |  |  |  | 3. TIME OF DEATH<br><b>7:56 A M</b>   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>220-42-4046</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>52</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Mar 2, 1943</b>                        |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Washington, D.C.</b>                                   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>NATIONAL NAVAL MEDICAL CENTER</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BETHESDA</b>  |  |  |  | 9c. COUNTY OF DEATH<br><b>MONTGOMERY</b>  |  |   |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>St. Mary's</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Mechanicsville</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO       |  |   |  |
| 10e. STREET AND NUMBER<br><b>2010 Patuxent Drive</b>   |  |  |  | 10f. ZIP CODE<br><b>20659</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>1991</b>   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                            |  |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2 years</b><br>College (1-4 or 5+) <b>2 years</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Photographer</b>  |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Government Contractor</b>                   |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Fremont Davis</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>June Shirley Thompson</b>   |  |  |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Sharon A. Davis</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2010 Patuxent Drive, Mechanicsville, MD 20659</b>                                       |  |  |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Cedar Hill Cemetery</b>  |  | DATE<br><b>2/1/96</b>   |  | 20c. LOCATION — City or Town, State<br><b>Suitland, Maryland</b>                 |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Richard H. Gardiner</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Mattingley-Gardiner Funeral Home, P.A.<br/>P.O. Box 270, Leonardtown, Maryland 20650</b>   |  |  |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>END STAGE PULMONARY FIBROSIS</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br><br>d. DUE TO (OR AS A CONSEQUENCE OF):<br><br>Approximate Interval Between Onset and Death<br><b>5 years</b> |  |  |  |   |  |  |  |   |  |   |  |
| 23. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>  |  |  |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> 1 <input type="checkbox"/> YES <input type="checkbox"/> NO  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Norman Lee MC</i>  |  |   |  | 29c. LICENSE NUMBER<br><b>RES-000</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>1-29-96</b>   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>NORMAN LEE, LT, MC, USNR</b>   |  |  |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>NATIONAL NAVAL MEDICAL CENTER<br/>BETHESDA MD 20889-5600</b>                                      |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB -1 1996</b>  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |   |  |  |  |   |  |   |  |

30 0440

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 96 04944

|   |  |   |  |  |  |  |  |  |
|---|--|---|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>MARY ALICE DORSCH</b>                               |   |  |  | 2. Date of Death<br>Month Day Year<br><b>February 9 1996</b> |  | 3. Time of Death<br><b>10:30 a.m.</b>                      |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>St. Mary's Nursing Center</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Leonardtown</b>   |  | 4c. County of Death<br><b>St. Mary's</b>                   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>578-09-3586</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>81</b> Yrs.             |  | 8. Date of Birth (Month, Day, Year)<br><b>Jun 18, 1914</b> |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |   | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>St. Mary's</b>                             |  | 10c. City, Town or Location<br><b>Clements</b>             |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>P.O. Box 113</b>   |  | 10f. Zip Code<br><b>20624</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8th Grade</b><br>College (1-4 or 5+) <b>College (1-4 or 5+)</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Cafeteria Worker</b>  |  | 16b. Kind of Business/Industry<br><b>School</b>  |  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>William Martin Vallandingham</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Eva Guy</b>   |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Robert H. Dorsch, Jr.</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P.O. Box 45, Leonardtown, Maryland 20650</b>   |  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Queen of Peace Cemetery</b>  |  | 20c. Location - City or Town, State<br><b>2/13/96 Helen, Maryland</b>  |  |  |  |  |
| 21. Signature of Funeral Service Licensee<br><i>Michael L. Gardiner</i>   |  |   |  | 22. Name and Address of Facility<br><b>Mattingley-Gardiner Funeral Home, P.A.<br/>P.O. Box 270, Leonardtown, Maryland 20650</b>  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Respiratory Failure</b><br>Due to (or as a consequence of):<br><b>b. COPD</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |   |  |  |  |  |  |  |
| Approximate Interval Between Onset and Death<br><b>2 months</b>   |  |   |  |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Bronchoectasis, Aspiration Pneumonia</b><br><b>CHF</b>   |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |  |
|   |  |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |
|   |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |
|   |  | 28d. Describe how injury occurred   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |  |  |  |  |  |
| 29b. Signature and title of certifier<br><i>Zahir Yousaf M.D.</i>   |  |   |  | 29c. License number<br><b>D 27189</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>2/12/96</b>  |  |  |
| 30. Name and address of person who completed cause of death (from 23a) (Type, Print)<br><b>Dr. Zahir Yousaf 2417 Solomons Island Rd. Huntingtown, MD 20639</b>  |  |   |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 13 1996</b>   |  | 32. Registrar's Signature<br><i>Julia Davidson-Randall</i>  |  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

11-10-53

1. The first part of the report deals with the general situation of the project. It is noted that the project has been completed and that the results are satisfactory. The second part of the report deals with the specific details of the project. It is noted that the project was completed on time and that the results are satisfactory. The third part of the report deals with the conclusions of the project. It is noted that the project was completed on time and that the results are satisfactory. The fourth part of the report deals with the recommendations of the project. It is noted that the project was completed on time and that the results are satisfactory. The fifth part of the report deals with the summary of the project. It is noted that the project was completed on time and that the results are satisfactory.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 01945

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

SHIELA ANN DUFF

2. Date of Death

Month Day Year  
FEBRUARY 10, 1996

3. Time of Death

10:20AM

4a. Facility Name (If not institution, give street and number)

3542 CHATEAU DRIVE

4b. City, Town, or Location of Death

EAST NEW MARKET

4c. County of Death

DORCHESTER

Funeral  
Director

5. Social Security Number

405-74-5149

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

45 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
AUG. 22, 1950

9. Birthplace (State or Foreign Country)

MICHIGAN

Usual Residence of Decedent

10a. State

MD

10b. County

DORCHESTER

10c. City, Town or Location

EAST NEW MARKET

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3542 CHATEAU DRIVE

10f. Zip Code

21631

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4or 5+)

16. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

ASSEMBLY LINE WORKER

16b. Kind of Business/Industry

MANUFACTURING

17. Father's Name (First, Middle, Last)

ORVILLE MASON

18. Mother's Name (First, Middle, Maiden Surname)

MARGIE BURTON

19a. Informant's Name/Relationship (Type, Print)

JAMES W. DUFF /HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3542 CHATEAU DRIVE, EAST NEW MARKET, MD 21631

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

GREEN HILL CEMETERY

Date

2/15

20c. Location - City or Town, State

MIDDLESBORO, KY

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

ZELLER FUNERAL HOME, P. O. BOX 207,  
106 MAIN STREET, EAST NEW MARKET, MD 2163123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a.

COR PULMONALE

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

5mo

b.

EMPHYSEMA

Due to (or as a consequence of):

1/RS

c.

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

SMOKER

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
injury

M

28c. Injury et  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how Injury occurred

29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D22773

29d. Date signed (Month, Day, Year)

2/12/96

30. Name and address of person who completed cause of death (Item 22a) (Type, Print)

HUBERT L. FIERY JR 503 BY2W ST CAMBRIDGE MD 20613

31. Date filed (Month, Day, Year)

FEB 13 1996

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

2000 2

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the study and the objectives of the research.

2. The second part of the report is a detailed description of the methodology used in the study. It includes information about the sample size, the data collection methods, and the statistical analysis techniques.

3. The third part of the report is a discussion of the results of the study. It presents the findings of the research and compares them with the previous studies in the field.

4. The fourth part of the report is a conclusion and a list of references. The conclusion summarizes the main findings of the study and provides recommendations for future research. The references list the sources of information used in the study.

5. The fifth part of the report is an appendix. It contains supplementary information that is not included in the main body of the report, such as raw data, additional tables, and figures.

6. The sixth part of the report is a bibliography. It lists the sources of information used in the study, including books, articles, and other documents.

7. The seventh part of the report is a glossary. It defines the key terms and concepts used in the study, ensuring that the reader understands the meaning of the words used.

8. The eighth part of the report is a list of figures. It provides a brief description of each figure and its location in the report, allowing the reader to find the figures easily.

9. The ninth part of the report is a list of tables. It provides a brief description of each table and its location in the report, allowing the reader to find the tables easily.



ITEM: 4. &amp; 7. PER F.H. FILM G-733 3/6/96 t.t

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

96 04946

REG. NO.

|  |  |  |  |   |  |  |   |
|--|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>WESLEY E. DOBSON</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>2</b> DAY <b>10</b> YEAR <b>1996</b>   |  | 3. TIME OF DEATH<br><b>1725</b> M  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>216-07-2372</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>87</b> YRS.  |  | 7. DATE OF BIRTH<br><b>12-31-08</b><br><b>July 26, 1941</b>                      |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>213 W. Central Avenue</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Federalsburg</b>  |  | 9c. COUNTY OF DEATH<br><b>Caroline</b>   |   |
| 10a. STATE<br><b>Md.</b>   |  |  |  | 10b. COUNTY<br><b>Caroline</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Federalsburg</b>                               |   |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  |   |  |  |   |
| 10e. STREET AND NUMBER<br><b>213 West Central Avenue</b>   |  |  |  | 10f. ZIP CODE<br><b>21632</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>                            |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WW II</b>   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>          |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+) <b>2</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Executive</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Trucking Company</b>   |  |  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Rev. C. H. Dobson</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mary Elizabeth Stewart</b>  |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Isabelle Adams Dobson</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>213 W. Central Ave., Federalsburg, MD 21632</b>   |  |  |   |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Cambridge Crematory 2-12</b>   |  | 20c. LOCATION — City or Town, State<br><b>Cambridge, MD</b>   |  |  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Michael F. Eskow</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Frampton-Hawkins-Eskow Funeral Home<br/>PO Box 43, Federalsburg, MD 21632</b>  |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Congestive Heart Failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>ASCVD</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>DUE TO (OR AS A CONSEQUENCE OF):<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Approximate interval Between Onset and Death<br><b>Weeks</b><br><b>years</b> |  |  |  |   |  |  |   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |  |   |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |  |   |  |  |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |   |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)     |   |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>William J. Ansfield</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>DO2444</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>2/10/96</b>                            |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>WILLIAM J. ANSFELD, MD, 505 DUTCHMAN'S LANE, EASTON, MD</b>  |  |  |  |   |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 12 1996</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Judith A. Davidson-Randall</b>  |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04947

|  |  |  |  |   |  |  |  |   |  |   |  |                                      |  |  |  |
|--|--|--|--|---|--|--|--|---|--|---|--|--------------------------------------|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>RAY A DUNN III</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>Feb</b> DAY <b>7</b> YEAR <b>96</b>  |  | 3. TIME OF DEATH<br><b>0255 M</b>  |  |   |  |   |  |                                      |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>226 66 6189</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>47</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>MAR 2 48</b>                           |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Florida</b>  |  |   |  |                                      |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>North Arundel Hosp</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Glen Burnie</b>   |  |  |  | 9c. COUNTY OF DEATH<br><b>AA</b>  |  |   |  |                                      |  |  |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Anne Arundel</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Crofton</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO       |  |   |  |                                      |  |  |  |
| 10e. STREET AND NUMBER<br><b>1577 Eton Way</b>   |  |  |  | 10f. ZIP CODE<br><b>21114</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>                            |  |   |  |   |  |                                      |  |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>          |  |   |  |   |  |                                      |  |  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6</b> College (14 or 5+) <b>6</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Vice President</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>South Charles Realty</b>                    |  |   |  |   |  |                                      |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Ray A. Dunn Jr.</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Roberta B. Bryant</b>   |  |  |  |   |  |   |  |                                      |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Marco S. Dunn</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1577 Eton Way Crofton Maryland 21114</b>  |  |  |  |   |  |   |  |                                      |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Jonesboro Cemetery 2/10/96</b>                         |  |   |  | 20c. LOCATION — City or Town, State<br><b>Roseland Virginia</b>                  |  |   |  |   |  |                                      |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Robert E. Evans Pres</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Robert E. Evans Funeral Home, P.A.<br/>16000 Annapolis Road Bowie Maryland 20715</b>   |  |  |  |   |  |   |  |                                      |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Acute Cardiac Failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. Hypertensive Heart Disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br><br>d. DUE TO (OR AS A CONSEQUENCE OF):<br><br>Approximate interval Between Onset and Death<br><b>UNK</b> |  |  |  |   |  |  |  |   |  |   |  |                                      |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypertension</b>  |  |  |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |                                      |  |  |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |   |  |  |  |   |  |   |  |                                      |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | HOSPITAL:<br><input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA                  |  | 26. PLACE OF DEATH (Check only one)<br>OTHER:<br><input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                              |  |  |  |   |  |   |  |                                      |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |                                      |  |  |  |
|  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)     |  |   |  |   |  |                                      |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |  |   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>William P. Jones Deputy</b>   |  | 29c. LICENSE NUMBER<br><b>D06054</b> |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>2/8/96</b> |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>William P. Jones, MD 695 America 21035</b>   |  |  |  |   |  |  |  |   |  |   |  |                                      |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 09 1996</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Johi Anderson-Robert</b>  |  |  |  |   |  |   |  |                                      |  |  |  |

Page 10

Page 10

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04948

|   |  |   |  |  |  |  |  |  |  |   |  |   |  |
|---|--|---|--|--|--|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>AUDREY T. DAVIS</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>1</b> DAY <b>21</b> YEAR <b>96</b>  |  | 3. TIME OF DEATH<br><b>9:10p M</b>   |  |  |  |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>578-42-9144</b>   |  | 5. SEX<br><b>1</b> M <b>2</b> F   |  | 6. AGE (In yrs. last birthday)<br><b>64</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>6/28/31</b>                        |  |  |  |   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Manor Care</b>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Bethesda</b>   |  | 9c. COUNTY OF DEATH<br><b>Montgomery</b>                                     |  |  |  |   |  |   |  |
| 10a. STATE<br><b>DC</b>   |  |   |  | 10b. COUNTY<br><b>N/A</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Washington</b>                             |  |  |  |   |  |   |  |
| 10d. INSIDE CITY LIMITS?<br><b>1</b> YES <b>2</b> NO  |  |   |  | 10e. STREET AND NUMBER<br><b>2618 Northhampton St NW</b>   |  |  |  |  |  |   |  |   |  |
| 10f. ZIP CODE<br><b>20015</b>   |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |  |  |  |  |   |  |   |  |
| 11. MARITAL STATUS<br><b>3</b> Widowed <b>4</b> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> YES <b>2</b> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> YES <b>2</b> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>      |  |  |  |   |  |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>12 Yrs</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Teacher</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Education</b>   |  |  |  |  |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Aubrey Thornton</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Virgie Henry</b>   |  |  |  |  |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Debra D. Davis</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1308 27th St SE, Wash, DC 20020</b>              |  |  |  |  |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State<br><b>4</b> Donation <b>5</b> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Lincoln Memorial</b>  |  | DATE<br><b>1/25/96</b>   |  | 20c. LOCATION — City or Town, State<br><b>Suitland, Md.</b>                  |  |  |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Juan Smith</b>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>John T. Rhines Co., Inc.<br/>3030 12th St NE, DC 20017</b>  |  |  |  |  |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Acute Myocardial Infarction</b><br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><b>Atherosclerotic coronary Heart Disease</b><br><b>Shuntic mellitus Type I</b> |  |   |  |  |  |  |  | Approximate Interval Between Onset and Death<br><b>1hr.</b><br><b>5yrs</b><br><b>12yrs</b> |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Congestive Heart Failure - Chronic</b><br><b>Rheumatoid arthritis</b>  |  |   |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><b>1</b> YES <b>2</b> NO                                 |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1</b> YES <b>2</b> NO |  |   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |   |  |  |  |  |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1</b> YES <b>2</b> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA<br>OTHER: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify) |  |  |  |  |  |  |  |   |  |   |  |
| 27. MANNER OF DEATH<br><b>1</b> Natural <b>5</b> Pending Investigation<br><b>3</b> Suicide <b>6</b> Could not be determined<br><b>4</b> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br><b>1</b> YES <b>2</b> NO                             |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  |   |  |
|   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |  |  |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><b>1</b> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>William Kurstin MD</b>                         |  | 29c. LICENSE NUMBER<br><b>D02906</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>1/22/96</b> |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>William Kurstin MD</b>  |  |   |  |  |  |  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>1/22/96</b>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><b>John A. ...</b>  |  |  |  |  |  |   |  |   |  |

JAN 29 1996

1951 1952

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR  |  |   |                                | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 96 04949  |  |
|---|--|---|--------------------------------|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)  |  |   |                                | 2. DATE OF DEATH   |  |  |  | 3. TIME OF DEATH  |  |
| WILLIAM C. DAVIS  |  |   |                                | FEB. 6, 1996   |  |  |  | 1:00 A M  |  |
| 4. SOCIAL SECURITY NUMBER   |  | 5. SEX  | 6. AGE (In yrs. last birthday) | 7. DATE OF BIRTH   |  | 8. BIRTHPLACE (State or Foreign Country)                     |  |   |  |
| 173-14-3866   |  | 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F            | 75 YRS.                        | APR. 13, 1920  |  | PA.  |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)  |  |   |                                | 9b. CITY, TOWN OR LOCATION OF DEATH  |  |  |  | 9c. COUNTY OF DEATH   |  |
| KENSINGTON GARDENS NURSING HOME   |  |   |                                | KENSINGTON   |  |  |  | MONTGOMERY  |  |
| 10a. STATE  |  |   |                                | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION                                  |  | 10d. INSIDE CITY LIMITS?  |  |
| MD.   |  |   |                                | MONTGOMERY   |  | KENSINGTON   |  | 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER  |  |   |                                | 10f. ZIP CODE  |  | 10g. CITIZEN OF WHAT COUNTRY?                                |  |   |  |
| 3514 NIMITZ RD.   |  |   |                                | 20895  |  | U.S.A.   |  |   |  |
| 11. MARITAL STATUS  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?                                     |                                | 13. WAS DECEDENT OF HISPANIC ORIGIN?   |  | 14. RACE — American Indian, Black, White, etc.               |  |   |  |
| 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married  |  | 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO         |                                | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | Specify: WHITE   |  |   |  |
| 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | IF YES, GIVE WAR OR DATES<br>WWII   |                                | Specify:   |  |  |  |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)   |  |   |                                | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)   |  | 16b. KIND OF BUSINESS/INDUSTRY                               |  |   |  |
| Elementary/Secondary (0-12) 12  |  |   |                                | College (1-4 or 5+) College  |  | PRINTER  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)   |  |   |                                | 18. MOTHER'S NAME (First, Middle, Maiden Surname)  |  |  |  |   |  |
| WILLIAM BURCY DAVIS   |  |   |                                | RUTH NAOMI ESTRIGHT  |  |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)  |  |   |                                | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)  |  |  |  |   |  |
| WILLIAM C. DAVIS JR.  |  |   |                                | SAME AS ITEM #10   |  |  |  |   |  |
| 20a. METHOD OF DISPOSITION  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) |                                | DATE   |  | 20c. LOCATION — City or Town, State                          |  |   |  |
| 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State   |  | CHAMBERS CREMATORY  |                                | 2/6  |  | RIVERDALE, MD.   |  |   |  |
| 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |   |                                |  |  |  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE   |  |   |                                | 22. NAME AND ADDRESS OF FACILITY   |  |  |  |   |  |
| W.W. Chambers   |  |   |                                | W. W. CHAMBERS CO. INC., SILVER SPRING, MD. 20910  |  |  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. |  |   |                                | Approximate Interval Between Onset and Death   |  |  |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →   |  |   |                                | 3 months   |  |  |  |   |  |
| Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  |  |   |                                | 5 months   |  |  |  |   |  |
| a. METASTATIC Lung Cancer   |  |   |                                |  |  |  |  |   |  |
| b. LARGE CELL CARCINOMA OF Lung   |  |   |                                |  |  |  |  |   |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):   |  |   |                                |  |  |  |  |   |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):   |  |   |                                |  |  |  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |                                | 24a. WAS AN AUTOPSY PERFORMED?   |  |  |  |   |  |
| Chronic ATRIAL Fibrillation   |  |   |                                | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>   |  |   |                                | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  |  |  |  |   |  |
|   |  |   |                                | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?  |  |   |                                | 26. PLACE OF DEATH (Check only one)  |  |  |  |   |  |
| 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |   |                                | HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |   |  |
| 27. MANNER OF DEATH   |  | 28a. DATE OF INJURY (Month, Day, Year)  |                                | 28b. TIME OF INJURY  |  | 28c. INJURY AT WORK?   |  | 28d. DESCRIBE HOW INJURY OCCURRED                                       |  |
| 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation  |  |   |                                | M  |  | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |   |  |
| 2 <input type="checkbox"/> Accident   |  |   |                                |  |  |  |  |   |  |
| 3 <input type="checkbox"/> Suicide  |  |   |                                |  |  |  |  |   |  |
| 4 <input type="checkbox"/> Homicide   |  |   |                                |  |  |  |  |   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |                                | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |   |  |
|   |  |   |                                |  |  |  |  |   |  |
| 29a. CERTIFIER (Check only one)   |  |   |                                | 29c. LICENSE NUMBER  |  |  |  |   |  |
| 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                        |  |   |                                | DO 2470  |  |  |  |   |  |
| 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |                                |  |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER   |  |   |                                | 29d. DATE SIGNED (Month, Day, Year)  |  |  |  |   |  |
| Eugene P. Libre MD  |  |   |                                | FEB 6, 1996  |  |  |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)   |  |   |                                |  |  |  |  |   |  |
| EUGENE P. LIBRE M.D. 10400 CONNECTICUT AVE  |  |   |                                | KENSINGTON MD. 20895   |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)   |  |   |                                | 32. REGISTRAR'S SIGNATURE  |  |  |  |   |  |
| FEB 07 1996   |  |   |                                | Julia Davidson Randall   |  |  |  |   |  |

2404-1

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 04950

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Addison H. Darden

2. Date of Death  
Month Day Year  
February 4, 1996

3. Time of Death  
2:20 AM

4a. Facility Name (If not institution, give street and number)

Montgomery General Hospital

4b. City, Town, or Location of Death

Olney

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

563-05-2651

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

May 27, 1912

9. Birthplace (State or Foreign Country)

Louisiana

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3330 North Leisure World Blvd., #501

10f. Zip Code

20906

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) 12

College (1-4or 5+) 1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Stockbroker

16b. Kind of Business/Industry

Securities

17. Father's Name (First, Middle, Last)

Addison G. Darden

18. Mother's Name (First, Middle, Maiden Surname)

Isabel Queen Home

19a. Informant's Name/Relationship (Type, Print)

Jeanne S. Darden

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Same as 10

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crematory

Date

2/5/96

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licensee

Green H. Rapp

22. Name and Address of Facility

Rapp Funeral Services, P. A.  
933 Gist Avenue, Silver Spring, MD 20910

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardogenic shock

Approximate Interval Between Onset and Death

2 hr

Due to (or as a consequence of):

b. Acute myocardial infarction

8 hr

Due to (or as a consequence of):

c. Coronary artery disease

hrs.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

acute mitral regurgitation

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Roger F. Leonard MD

29c. License number

D 28791

29d. Date signed (Month, Day, Year)

2/4/96 0235

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Roger F. Leonard MD, 10401 Old Georgetown Rd, Bethesda MD 20814

31. Date filed (Month, Day, Year)

FEB 06 1996

32. Registrar's Signature

John Anderson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended #8, 2/14/96, MRT, Montg. Cty. **Certificate of Death**

Reg. No. **96 04951**

|   |  |   |  |                                      |  |  |  |   |
|---|--|---|--|--------------------------------------|--|--|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Philip F. Delisi</b>  |   |  |                                      | 2. Date of Death<br>Month <b>February</b> Day <b>03</b> Year <b>1996</b>   |  | 3. Time of Death<br><b>1:35 AM</b>   |   |
|   | 4a. Facility Name (If not Institution, give street and number)<br><b>Suburban Hospital</b>   |   |  |                                      | 4b. City, Town, or Location of Death<br><b>Bethesda</b>  |  | 4c. County of Death<br><b>Montgomery</b>   |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>579-69-8845</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>74</b> Yrs.   | If Under 1 Year<br>Months Days       | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>August 14, 1921</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Washington, D.C.</b> |
|   | Usual Residence of Decedent  |   |  |                                      |  |  |  |   |
| To Be Completed by Funeral Director   | 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>Montgomery</b>   |                                      | 10c. City, Town or Location<br><b>Bethesda</b>   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |
|   | 10e. Street and Number<br><b>9407 Bulls Run Parkway</b>  |   |  |                                      | 10f. Zip Code<br><b>20817</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |
|   | 11. Marital Status<br><input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>1944-</b><br>If Yes, Give Year or Dates: <b>1946</b> |                                      | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |   |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>4</b>   |   |  |                                      | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Aerospace Engineer</b>   |  | 16b. Kind of Business/Industry<br><b>Engineering</b>   |   |
|   | 17. Father's Name (First, Middle, Last)<br><b>Salvatore Delisi</b>   |   |  |                                      | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Irene Attino</b>   |  |  |   |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Helen Delisi</b>  |   |  |                                      | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9407 Bulls Run Parkway Bethesda, Md. 20817</b>   |  |  |   |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Ft. Lincoln Crematory 2/6/96</b>  |                                      | Date<br><b>2/6/96</b>  |  | 20c. Location - City or Town, State<br><b>Brentwood, Md.</b>                                   |   |
|   | 21. Signature of Funeral Service Licensee<br><i>Edmund A. Gregorich</i>  |   |  |                                      | 22. Name and Address of Facility<br><b>Hines-Rinaldi Funeral Home<br/>11800 New Hampshire Ave. Silver Spring, Md. 20904</b>  |  |  |   |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Acute Myocardial Infarction</b><br>Due to (or as a consequence of):<br><b>b. Coronary Artery Atherosclerosis</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |  |                                      |  |  |  |   |
|   | 23b. Approximate Interval Between Onset and Death<br><b>Hours</b><br><b>Years</b>  |   |  |                                      |  |  |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |                                      |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |
|   |  |   |  |                                      |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |
|   |  |   |  |                                      |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                      |  |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>      |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. Describe how injury occurred    |  |  |  |   |
|   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |                                      |  |  |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |  |                                      |  |  |  |   |
| 29b. Signature and title of certifier<br><i>Harris M. Kenner</i>  |  |   |  | 29c. License number<br><b>D06019</b> |  | 29d. Date signed (Month, Day, Year)<br><b>February 3, 1996</b>   |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. Harris M. Kenner, MD 6410 Rockledge Dr. Bethesda, Md. 20817</b>  |  |   |  |                                      |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>FEB 08 1996</b>   |  | 32. Registrar's Signature<br><i>John Andrew Radell</i>  |  |                                      |  |  |  |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04952

|   |  |   |  |  |  |  |  |   |  |  |  |
|---|--|---|--|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>CORINE EVANS</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>February 2, 1996</b>  |  |  |  | 3. TIME OF DEATH<br><b>6:25 P.</b>  |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>250-22-9703</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>82</b> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Aug. 1, 1913</b>                      |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Santee, SC</b>   |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Allegis Heath Care Center</b>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Bethesda</b>   |  |  |  | 9c. COUNTY OF DEATH<br><b>Montgomery</b>  |  |  |  |
| RESIDENCE OF DECEDENT   |  |   |  |  |  |  |  |   |  |  |  |
| 10a. STATE<br><b>District of Columbia</b>   |  | 10b. COUNTY<br><b>Washington</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Washington</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO       |  |  |  |
| 10e. STREET AND NUMBER<br><b>2508 4th Street, N. E.</b>   |  |   |  | 10f. ZIP CODE<br><b>20002</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>                              |  |   |  |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>African American</b> |  |   |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>3</b><br>College (1-4 or 5+) <b>College</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Hotel Maid</b>              |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Private</b>   |  |  |  |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Solomon Gabson</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Rosa Whittaker</b>   |  |  |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Tommie Surratt</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2508 4th Street, N.E., Washington, D. C. 20002</b>   |  |  |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Harmony Memorial Park 2/10/96</b>                         |  | 20c. LOCATION — City or Town, State<br><b>Landover, Maryland</b>   |  |  |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>John T. Stewart III</b>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>STEWART FUNERAL HOME, Inc.,<br/>4001 Benning Road, N. E., Washington, D.C.</b>  |  |  |  |   |  |  |  |
| PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><b>sepsis</b><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>multil decomp - stage IV</b><br><b>CAD</b> |  |   |  |  |  |  |  | Approximate interval between Onset and Death  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>hypertension</b>   |  |   |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide   |  |   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO           |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |
|   |  |   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                          |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>John T. Stewart III</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>DO 3518</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>2/8/96</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Elliot R. Goldstein 9410 Old Georgetown Rd. Bethesda MD 20814</b>   |  |   |  |  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 09 1996</b>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><b>John T. Stewart III</b>  |  |  |  |   |  |  |  |

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04953

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

John Clark Erskine

2. Date of Death

Feb 2 1996

Day Year

3. Time of Death

4:30 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

277-12-9958

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

78

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Sept. 1, 1917

9. Birthplace (State or Foreign Country)

Japan

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6018 Kingsford Road

10f. Zip Code

20817

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: World War II

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Intelligence Officer

16b. Kind of Business/Industry

Central

Intelligence Agency

17. Father's Name (First, Middle, Last)

William H. Erskine

18. Mother's Name (First, Middle, Maiden Surname)

Virginia Stewart

19a. Informant's Name/Relationship (Type, Print)

Ferne S. Erskine

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6018 Kingsford Road, Bethesda, Maryland 20817

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

February 20, 1996

Arlington National Cemetery

20c. Location - City or Town, State

Arlington, Virginia

21. Signature of Funeral Service Licensee

M00831

Barbara McMullen Lawrence

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/

Bethesda-Chevy Chase, Inc. 7557 Wisconsin

Avenue, Bethesda, Maryland 20814-3501

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Respiratory Distress Syndrome

Due to (or as a consequence of):

10d

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Aspiration Pneumonia

Due to (or as a consequence of):

10d

c. Transient Ischemic Attacks

Due to (or as a consequence of):

5 years

d. Arteriosclerotic Cerebral Vascular Disease

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

gastrointestinal bleeding

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death:

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Jeremy V. Cooke

29c. License number

D04602

29d. Date signed (Month, Day, Year)

2/3/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jeremy Cooke 10400 Conn Ave, Kensington MD

31. Date filed (Month, Day, Year)

FEB 08 1996

32. Registrar's Signature

John Davidson Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



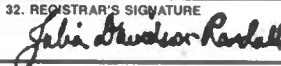
1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04954

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Shirley Estrain</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>FEB</b> DAY <b>1</b> YEAR <b>1996</b>  |  | 3. TIME OF DEATH<br><b>6:55 P M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>100-24-8556</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br><b>93</b> YRS. | 7. DATE OF BIRTH (Month, Day, Year)<br><b>8/2/1902</b>  |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Russia</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Montgomery general Hospital</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Olney</b>   |  | 9c. COUNTY OF DEATH<br><b>Montgomery</b>  |  |
| 10a. STATE<br><b>Md.</b>  |  |  |  | 10b. COUNTY<br><b>Montgomery</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Silver Spring</b>   |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  | 10e. STREET AND NUMBER<br><b>14508 Homecrest Rd.</b>  |  |   |  |
| 10f. ZIP CODE<br><b>20906</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>12</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Own Home</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Rafael Cohen</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Esther Mishkin</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Jay Estrain</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>827 Caddington Ave. Silver Spring, Md. 20901</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>King David Memorial Gardens 2/4</b>  |  | 20c. LOCATION — City or Town, State<br><b>Falls Church, Va.</b>   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Edward Sagel Funeral Direction<br/>1091 Rockville Pike Rockville, Md. 20852</b>                  |  |
| 21. SIGNATURE OF FUNERAL HOME LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Edward Sagel Funeral Direction<br/>1091 Rockville Pike Rockville, Md. 20852</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. myocardial infarction</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b><br>b. _____<br>c. _____<br>d. _____ |  |  |  |   |  | Approximate Interval Between Onset and Death<br><b>1 hour</b>   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypertension</b>   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br> MD   |  |  |  | 29c. LICENSE NUMBER<br><b>035762</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>2/2/96</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>MICHAEL SCHINDLER 1106 SPRING STREET SILVER SPRING MD 20910</b>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 06 1996</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>  |  |   |  |



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04955

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

|   |   |  |  |   |  |   |   |   |                                  |          |                                    |         |  |         |
|---|---|--|--|---|--|---|---|---|----------------------------------|----------|------------------------------------|---------|--|---------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Helen K. Friend</b>  |   |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Feb. 5 1996</b>  |  | 3. TIME OF DEATH<br><b>5:00 p.m.</b>  |   |   |                                  |          |                                    |         |  |         |
| 4. SOCIAL SECURITY NUMBER<br><b>218-16-4145</b>   |   | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>73</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Mar 10, 1922</b>                                      |   |   |                                  |          |                                    |         |  |         |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>   |   | 9a. FACILITY NAME (If not institution, give street and number)<br><b>6347 Hoyes-Sang Run Rd.</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>McHenry</b>   |  | 9c. COUNTY OF DEATH<br><b>Garrett</b>   |   |   |                                  |          |                                    |         |  |         |
| 10a. STATE<br><b>Maryland</b>   |   | 10b. COUNTY<br><b>Garrett</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>McHenry</b>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   |   |                                  |          |                                    |         |  |         |
| 10e. STREET AND NUMBER<br><b>6347 Hoyes-Sang Run Road</b>   |   |  |  | 10f. ZIP CODE<br><b>21541</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |   |                                  |          |                                    |         |  |         |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>white</b>                      |   |   |                                  |          |                                    |         |  |         |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>Elementary/Secondary (9-12)</b><br><b>8 th</b>  |   | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>   |  | 15b. KIND OF BUSINESS/INDUSTRY<br><b>Own Home</b>   |  |   |   |   |                                  |          |                                    |         |  |         |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Jacob F. Suter</b>  |   |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Iva Pearl Sliger</b>  |  |   |   |   |                                  |          |                                    |         |  |         |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Larry L. Suter</b>   |   |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>608 Water St., Friendsville, MD 21531</b>   |  |   |   |   |                                  |          |                                    |         |  |         |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Sang Run Cem. Feb. 9, 1996</b>   |  | 20c. LOCATION — City or Town, State<br><b>McHenry, MD</b>   |  |   |   |   |                                  |          |                                    |         |  |         |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |   |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Newman Funeral Homes, P.A., P.O. Box 275<br/>179 Miller St., Grantsville, MD 21536</b>   |  |   |   |   |                                  |          |                                    |         |  |         |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Ventricular Arrhythmia, Acute</b><br><br>Approximate Interval Between Onset and Death: <b>Sudden</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br><table border="0"> <tr> <td rowspan="4" style="vertical-align: middle; font-size: 4em;">{</td> <td>b. <b>Ischemic Heart Disease</b></td> <td>15 Years</td> </tr> <tr> <td>c. <b>Congestive Heart Failure</b></td> <td>5 years</td> </tr> <tr> <td>d. <b>Arteriosclerotic Cardio-Vascular Disease</b></td> <td>Unknown</td> </tr> </table> |   |  |  |   |  |   |   | { | b. <b>Ischemic Heart Disease</b> | 15 Years | c. <b>Congestive Heart Failure</b> | 5 years | d. <b>Arteriosclerotic Cardio-Vascular Disease</b> | Unknown |
| {   | b. <b>Ischemic Heart Disease</b>  | 15 Years   |  |   |  |   |   |   |                                  |          |                                    |         |  |         |
|   | c. <b>Congestive Heart Failure</b>  | 5 years  |  |   |  |   |   |   |                                  |          |                                    |         |  |         |
|   | d. <b>Arteriosclerotic Cardio-Vascular Disease</b>  | Unknown  |  |   |  |   |   |   |                                  |          |                                    |         |  |         |
|   | PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Carcinoma of the bladder - 1992</b><br><b>Emphysema and hypothyroidism</b><br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/></b> |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   |                                  |          |                                    |         |  |         |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |   | 25. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |   |   |                                  |          |                                    |         |  |         |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                |   |   |                                  |          |                                    |         |  |         |
|   |   | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                    |   |   |                                  |          |                                    |         |  |         |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   |  |  |   |  |   |   |   |                                  |          |                                    |         |  |         |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><br><b>Herbert H. Leighton, M.D.</b>  |   |  |  | 29c. LICENSE NUMBER<br><b>D 05658</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>February 6, 1996</b>                                  |   |   |                                  |          |                                    |         |  |         |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Herbert H. Leighton, M.D., 502 E. Oak Street, Oakland, Maryland, 21550</b>  |   |  |  |   |  |   |   |   |                                  |          |                                    |         |  |         |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 09 1996</b>   |   | 32. REGISTRAR'S SIGNATURE<br>   |  |   |  |   |   |   |                                  |          |                                    |         |  |         |



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. DECEDENT'S NAME (First, Middle, Last)  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR  |  |  |  | 3. TIME OF DEATH  |  |   |  |
|---|--|--|--|---|--|--|--|---|--|---|--|
| BEATRICE JEAN FAIRGRIEVE  |  |  |  | FEBRUARY 3, 1996  |  |  |  | 12:45 A <sup>M</sup>  |  |   |  |
| 4. SOCIAL SECURITY NUMBER   |  | 5. SEX   |  | 6. AGE (In yrs. last birthday)  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)   |  | 8. BIRTHPLACE (State or Foreign Country)  |  |   |  |
| 216-22-5592   |  | 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 77 YRS.   |  | June 14, 1918  |  | Maryland  |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH   |  |  |  | 9c. COUNTY OF DEATH   |  |   |  |
| Sacred Heart Hospital   |  |  |  | Cumberland  |  |  |  | Allegany  |  |   |  |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |  |  |   |  |   |  |
| 10a. STATE  |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION   |  | 10d. INSIDE CITY LIMITS?   |  |   |  |   |  |
| Maryland  |  | Allegany   |  | Nikep   |  | 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO              |  |   |  |   |  |
| 10e. STREET AND NUMBER  |  |  |  | 10f. ZIP CODE   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?   |  |   |  |
| 17719 Lower Georges Creek Rd. S.W.  |  |  |  | 21546   |  |  |  | USA   |  |   |  |
| 11. MARITAL STATUS  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN?  |  | 14. RACE — American Indian, Black, White, etc.                                       |  |   |  |   |  |
| 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>Specify:           |  | Specify: White   |  |   |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |  |  |   |  |   |  |
| Elementary/Secondary (0-12) 10<br>College (1-4 or 5+) 0   |  | Homemaker  |  | Home  |  |  |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)   |  |  |  |   |  |   |  |
| William James Cameron   |  |  |  | Emma Moffatt  |  |  |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |  |  |  |   |  |   |  |
| Carol Kline   |  |  |  | 17733 Lower Georges Creek Rd. S.W. Box B-11, Nikep, Md. 21546                                 |  |  |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)  |  | DATE  |  | 20c. LOCATION — City or Town, State  |  |   |  |   |  |
| 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | Oak Hill Cemetery Feb. 6, 1996   |  |   |  | Lonaconing, Md   |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE   |  |  |  | 22. NAME AND ADDRESS OF FACILITY  |  |  |  |   |  |   |  |
| Jas E. McKee  |  |  |  | Eichhorn-McKenzie Funeral Home<br>Lonaconing, Md. 21539                                       |  |  |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ACUTE CEREBRAL ACCIDENT<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. CEREBRAL ARTERIOSCLEROSIS<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  |  |  | Approximate Interval Between Onset and Death<br>9 days<br>unknown   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>CONGESTIVE HEART FAILURE<br>OLD CEREBROVASCULAR ACCIDENT<br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |   |  |   |  |
| 27. MANNER OF DEATH   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
| 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident<br>3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide   |  |  |  |   |  |  |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER  |  |   |  |  |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)   |  |
| 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | S. Chang   |  |   |  |  |  | D25638  |  | February 4, 1996  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>SATURNINA CHANG, M.D. R136 FROSTBURG PLAZA FROSTBURG MARYLAND 21532  |  |  |  |   |  |  |  |   |  |   |  |
| 31. DATE FEB 08 1996 REGISTRAR'S SIGNATURE<br>John A. Davidson  |  |  |  |   |  |  |  |   |  |   |  |



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Amended #4, 2/7/96, D.B.I., Allegany Co.

1 - STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

96 04957

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>DORIS May FERGUSON/Ferguson  |  |  |  | 2. DATE OF DEATH<br>MONTH JANUARY DAY 26 YEAR 1996  |  | 3. TIME OF DEATH<br>0630 P M   |  |
| 4. SOCIAL SECURITY NUMBER<br>346-34-7682<br>840-02-5122  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>88 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>May 13, 1907   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>New York   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>Cumberland Nursing Home   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>CUMBERLAND, MD  |  |
| 9c. COUNTY OF DEATH<br>ALLEGANY  |  |  |  | 10a. STATE<br>Md.   |  | 10b. COUNTY<br>Allegany  |  |
| 10c. CITY, TOWN OR LOCATION<br>LaVale  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br>106 West St.   |  |
| 10f. ZIP CODE<br>21502   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  |  |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify: White   |  |  |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 3  |  |  |  |
| 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Nurse   |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Medical   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>John Martin   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Lila Oliver  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Eric Delaney   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>American Trust Bank Baltimore St.<br>Cumberland, Md. 21502   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Davis Memorial Cemt. Feb. 5, 96  |  |  |  |
| 20c. LOCATION — City or Town, State<br>Cumberland, Md.   |  |  |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Robert C. Adams  |  |  |  |
| 22. NAME AND ADDRESS OF FACILITY<br>Merritt-Adams Funeral Home<br>404 Decatur St. Cumberland, Md. 21502  |  |  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. Sepsis<br>b. Myocardial infarction<br>c. High blood pressure<br>d.<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |
| 24. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 weeks<br>10 yr<br>15 yr  |  |  |  | PART II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)<br>28b. TIME OF INJURY<br>M<br>28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |
| 28d. DESCRIBE HOW INJURY OCCURED   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>DR. VIC POONAI  |  |  |  | 29c. LICENSE NUMBER<br>D 36746  |  |  |  |
| 29d. DATE SIGNED (Month, Day, Year)<br>1/27/96   |  |  |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>DR. VIC POONAI 955 FREDERICK STREET CUMBERLAND, MD 21502   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>FEB 05 1996   |  |  |  | REGISTRAR'S SIGNATURE<br>John A. ...  |  |  |  |





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR  |  |   |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 96 04958  |  |   |  |
|---|--|---|--|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)  |  |   |  | 2. DATE OF DEATH   |  |   |  | 3. TIME OF DEATH  |  |   |  |
| Addie Fagan   |  |   |  | January 30, 1996   |  |   |  | 5:35 p. M   |  |   |  |
| 4. SOCIAL SECURITY NUMBER   |  | 5. SEX  |  | 6. AGE (In yrs. last birthday)   |  | 7. DATE OF BIRTH  |  | 8. BIRTHPLACE (State or Foreign Country)  |  |   |  |
| 214-22-1584   |  | 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                              |  | 99 YRS.  |  | Jan. 1, 1897  |  | Virginia  |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH  |  |   |  | 9c. COUNTY OF DEATH   |  |   |  |
| St. Mary's Nursing Center   |  |   |  | Leonardtown  |  |   |  | St. Mary's  |  |   |  |
| RESIDENCE OF DECEDENT   |  |   |  |  |  |   |  |   |  |   |  |
| 10a. STATE  |  | 10b. COUNTY   |  | 10c. CITY, TOWN OR LOCATION  |  | 10d. INSIDE CITY LIMITS?  |  |   |  |   |  |
| Maryland  |  | St. Mary's  |  | Hollywood  |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |   |  |   |  |
| 10e. STREET AND NUMBER  |  |   |  | 10f. ZIP CODE  |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?   |  |   |  |
| Route 3 Box 242   |  |   |  | 20636  |  |   |  | U.S.A.  |  |   |  |
| 11. MARITAL STATUS  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN?   |  | 14. RACE — American Indian, Black, White, etc.                          |  |   |  |   |  |
| 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  | Specify: Black  |  |   |  |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)   |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)   |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |
| Elementary/Secondary (0-12) College (1-4 or 5+)   |  |   |  | Homemaker  |  |   |  | Own Home  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)  |  |   |  |   |  |   |  |
| William Reid  |  |   |  | Fannie Fields  |  |   |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)  |  |   |  |   |  |   |  |
| Elouise Thomas Griffin  |  |   |  | 2623 Robb Street, Baltimore, Maryland 21218  |  |   |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)                   |  | DATE   |  | 20c. LOCATION — City or Town, State                                     |  |   |  |   |  |
| 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | St. Aloysius Cemetery   |  | 2/3/1996   |  | Leonardtown, Maryland   |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE   |  |   |  | 22. NAME AND ADDRESS OF FACILITY   |  |   |  |   |  |   |  |
| <i>Michael L. Gardiner</i>  |  |   |  | Mattingley-Gardiner Funeral Home, P.A.<br>P.O. Box 270, Leonardtown, Maryland 20650  |  |   |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |  |  |  |   |  | Approximate Interval Between Onset and Death  |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →   |  |   |  |  |  |   |  |   |  |   |  |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  |   |  |  |  |   |  |   |  |   |  |
| a. <i>Cardiac arrest</i><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |  |  |   |  |   |  |   |  |
| b. <i>Malnutrition + Dehydration</i><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |  |  |   |  |   |  |   |  |
| c. <i>Cerebrovascular accident</i><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |  |  |   |  |   |  |   |  |
| d. <i>Cerebrovascular atherosclerosis</i><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |  |  |   |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |   |  |  |  |   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |   |  | 26. PLACE OF DEATH (Check only one)  |  |   |  |   |  |   |  |
|   |  |   |  | HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |   |  |
| 27. MANNER OF DEATH   |  |   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                      |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
| 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  |   |  |  |  | M   |  |   |  |   |  |
|   |  |   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                              |  |   |  |
| 29a. CERTIFIER (Check only one)   |  |   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER  |  |   |  |   |  |   |  |
| 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  | <i>John F. Fenwick</i>   |  |   |  | 29c. LICENSE NUMBER<br>D01380   |  | 29d. DATE SIGNED (Month, Day, Year)<br>1-31-96  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)   |  |   |  |  |  |   |  |   |  |   |  |
| Dr. John F. Fenwick, M.D.   |  |   |  | Leonardtown, Maryland 20650  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)   |  |   |  | 32. REGISTRAR'S SIGNATURE  |  |   |  |   |  |   |  |
| FEB -1 1996   |  |   |  | <i>Julia Davidson-Randall</i>  |  |   |  |   |  |   |  |

0271

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04959

|   |  |  |  |   |
|---|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Willie Fenwick  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>February 5, 1996   |  | 3. TIME OF DEATH<br>2:00 A M  |
| 4. SOCIAL SECURITY NUMBER<br>217-46-8361  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 6. AGE (In yrs. last birthday)<br>74 YRS.  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>Aug 23, 1921 | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>35-B Coronado Drive   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Great Mills   |  | 9c. COUNTY OF DEATH<br>St. Mary's   |
| 10a. STATE<br>Maryland  |  | 10b. COUNTY<br>St. Mary's  |  | 10c. CITY, TOWN OR LOCATION<br>Great Mills  |
| 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |   |
| 10e. STREET AND NUMBER<br>35-B Coronado Drive   |  | 10f. ZIP CODE<br>20634   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |
| 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>Black   |  |  |  |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>1st Grade  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Laborer   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Farm  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Gerald Fenwick   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Mamie Elizabeth Toney   |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>James Ignatius Fenwick  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>21356 Lexington Dr., Great Mills, MD 20634  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Our Lady's Cemetery 2/7/96  |  | 20c. LOCATION — City or Town, State<br>Leonardtwn, Maryland   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Michael F. Gardiner</i>   |  | 22. NAME AND ADDRESS OF FACILITY<br>Mattingley-Gardiner Funeral Home, P.A.<br>P.O. Box 270, Leonardtown, Maryland 20650  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cardiac Failure</i><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <i>Acute Myocardial Infarction</i><br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> |  |  |  |   |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>J. Patrick Jarboe, M.D.</i>   |  | 29c. LICENSE NUMBER<br>D 06419   |  | 29d. DATE SIGNED (Month, Day, Year)<br>2-5-96   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>J. Patrick Jarboe, M.D. Leonardtown, Maryland 20650  |  |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br>FEB -6 1996  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |   |

2692 21

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 96 04960

Amended # 17. P.G. Co. 2-12-96 CR

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Clifton M. Fowler

2. Date of Death

February 3, 1996

3. Time of Death

9 PM

Funeral  
Director

4e. Facility Name (If not Institution, give street and number)

3001 BRANCH AVENUE #635

4b. City, Town, or Location of Death

DISTRICT HEIGHTS

4c. County of Death

PRINCE GEORGES

5. Social Security Number

577 28 5727

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

AUG. 28, 1920

9. Birthplace (State or Foreign Country)

WASHINGTON, D.C.

Usual Residence of Decedent

10a. State

MD.

10b. County

PRINCE GEORGES

10c. City, Town or Location

DISTRICT HEIGHTS

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3001 BRANCH AVENUE #635

10f. Zip Code

20748

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

MILITARY

16b. Kind of Business/Industry

GOVERNMENT

17. Father's Name (First, Middle, Last)

WILLIAM

F. L.

FOWLER

18. Mother's Name (First, Middle, Maiden Surname)

DORA

HARDY

19a. Informant's Name/Relationship (Type, Print)

WILLIAM CARROLL/NEPHEW

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3210 BEVERLY DRIVE, HUNTINGTOWN, MD. 20639

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CHESAPEAKE CREMATORY

Date

2/5/96

20c. Location - City or Town, State

BELTSVILLE, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

E.M. DUDLEY FUNERAL HOME  
3200 RHODE ISLAND AVE., MT. RAINIER, MD. 20712

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Myocardial infarction*  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Chronic obstructive pulmonary disease*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

DAIR 30

29d. Date signed (Month, Day, Year)

February 4, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Augusto P. Rodriguez MD, 5009 Kayburn Ct. Cp Spr. Md 20748

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 06 1996

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04961

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ALEXANDER WASHINGTON FITCH</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>FEBRUARY 7 1996</b>  |  | 3. TIME OF DEATH<br><b>10:54 AM</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>224-26-5609</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>74</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Feb 17, 1921</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Holy Cross Hospital</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Silver Spring</b>   |  | 9c. COUNTY OF DEATH<br><b>Montgomery</b>   |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |  |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Montgomery</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Kensington</b>  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                    |  |
| 10e. STREET AND NUMBER<br><b>10719 Shaftsbury Street,</b>  |  |  |  | 10f. ZIP CODE<br><b>20895</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Black</b>   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6th Grade</b><br>College (1-4 or 5+) <b>College (1-4 or 5+)</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Plumbers Helper</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Plumbing Co.</b>   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Thomas Fitch</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Gertrude Hawkins</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print) (Wife)<br><b>Mrs Celestine B. Fitch</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) (20895)<br><b>10719 Shaftsbury St, Kensington, Md</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Parklawn Memorial Pk. 2/13</b>   |  | 20c. LOCATION — City or Town, State<br><b>Rockville, Md</b>   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Snowden Funeral Home P.A. 20850<br/>246 N. Washington St, Rockville, Md</b> |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>George L. Snowden</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Snowden Funeral Home P.A. 20850<br/>246 N. Washington St, Rockville, Md</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  | a. <b>Chronic Renal failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  | Approximate Interval Between Onset and Death<br><b>2 yrs.</b>  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  | b. <b>Chronic Glomerulo nephrosclerosis.</b><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  | 3 yrs.   |  |
|  |  | c. <b>Diabetes mellitus</b><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  | Several years.   |  |
|  |  | d.   |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypertension</b><br><b>coronary artery Disease.</b>   |  |  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                               |  |
|  |  | 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  |
|  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Amit Rajvanshi MD.</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>D37891</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>FEBRUARY 7 1996</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>AMIT RAJVANSHI MD 121 Congressional Ln #409 Rockville, MD-20852</b>  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 09 1996</b>  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>  |  |   |  |  |  |

1723/2



Amended #12, 2/5/96, MRT, Montgomeryf County

1 -  
FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04962

|   |  |  |  |   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Richard Elmer Forrester   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>February 1, 1996  |  |  |  | 3. TIME OF DEATH<br>9:10 A M  |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br>564-44-3943  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>67 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>November 15, 1928                             |  | 8. BIRTHPLACE (State or Foreign Country)<br>California  |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>3804 Greenly Street   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Silver Spring  |  |  |  | 9c. COUNTY OF DEATH<br>Montgomery   |  |   |  |
| 10a. STATE<br>Maryland  |  | 10b. COUNTY<br>Montgomery  |  | 10c. CITY, TOWN OR LOCATION<br>Silver Spring  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO       |  |   |  |
| 10e. STREET AND NUMBER<br>3804 Greenly Street   |  |  |  | 10f. ZIP CODE<br>20906  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |  |   |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>1953-1955  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                     |  |   |  |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>4   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Senior Analyst   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Computers   |  |  |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Elmer Forrester  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Edna Sherwood  |  |  |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Shirley A. Forrester  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3804 Greenly Street, Silver Spring 20906   |  |  |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Norbeck Memorial Park 2/5/96  |  | 20c. LOCATION — City or Town, State<br>Olney, Maryland  |  |  |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Andrew J. Cole</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Francis J. Collins Funeral Home, Inc.<br>500 University Blvd.W. Sil.Spr.MD 20901  |  |  |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Acute Myocardial Infarction</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |  |  | Approximate Interval Between Onset and Death<br><i>Immediate</i>  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>COPD; Condroma of Lumbar Spine<br/>Bladder Cancer; Colonic Stricture; GERD</i><br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>  |  |  |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
| 28a. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)  |  | 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>D. Henjum MD Attending</i>  |  |  |  | 29c. LICENSE NUMBER<br><i>D35045</i>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>February 1, 1996</i>                       |  |   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>Philip Henjum, MD 34160 Kentwood Court #200 Olney, MD 20832</i>   |  |  |  |   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><i>FEB 02 1996</i>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson Randall</i>   |  |  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

96 04963

REG. NO.

|   |  |  |  |   |  |   |   |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Casto Ferragut  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>February 4, 1996  |  | 3. TIME OF DEATH<br>1:30 PM   |   |
| 4. SOCIAL SECURITY NUMBER<br>578-86-7950  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>82 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>Sept. 4, 1913  |   |
| 8. BIRTHPLACE (State or Foreign Country)<br>Cuba  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>3612 Taylor Street   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Chevy Chase  |  | 9c. COUNTY OF DEATH<br>Montgomery   |   |
| 10a. STATE<br>Maryland  |  | 10b. COUNTY<br>Montgomery  |  | 10c. CITY, TOWN OR LOCATION<br>Chevy Chase  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br>3612 Taylor Street  |  |  |  | 10f. ZIP CODE<br>20815  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>United States  |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO Specify: Cuban |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                                |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>5+  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Officer  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Agricultural Development/<br>IDB  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>Lignorio Ferragut  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Rafaela Leon   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>Nelson J. Ferragut  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>9919 Markham Street, Silver Spring, Maryland 20901   |  |   |   |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Montgomery Crematorium, Inc. Feb 7, 1996  |  | 20c. LOCATION — City or Town, State<br>Bethesda, Maryland   |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Michael E. Higgins</i>  |  | 22. NAME AND ADDRESS OF FACILITY<br>Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501  |  |   |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. Myocardial Infarction<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |   |  |   |   |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>   |  |  |  |   |  |   |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |   |
|   |  | 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |   |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Francis C. Mayle, Jr.</i>  |  | 29c. LICENSE NUMBER<br>D07099   |  | 29d. DATE SIGNED (Month, Day, Year)<br>February 5, 1996   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Francis C. Mayle, Jr. 10215 Fernwood Rd. #301, Bethesda, MD 20817-1106   |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br>FEB 06 1996  |  | 32. REGISTRAR'S SIGNATURE<br><i>John D. Walker-Randall</i>   |  |   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04964

|   |   |   |   |  |  |   |   |  |
|---|---|---|---|--|--|---|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>WILLIAM MURRAY FRANKLIN</b>  |   |   |  | 2. Date of Death<br>Month Day Year<br><b>FEBRUARY 1, 1996</b>  |   | 3. Time of Death<br><b>11:30 AM</b>                                     |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>11700 OLD COLUMBIA PIKE, #404</b>  |   |   |  | 4b. City, Town, or Location of Death<br><b>SILVER SPRING</b>   |   | 4c. County of Death<br><b>MONTGOMERY</b>                                |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>577-48-2615</b>   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input type="checkbox"/> F<br><b>X</b>   | 7. Age (In yrs. last birthday)<br><b>94</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth<br>(Month, Day, Year)<br><b>NOV 30, 1901</b>   | 9. Birthplace (State or Foreign Country)<br><b>RUSSIA</b>               |  |
|   | Usual Residence of Decedent   |   |   |  |  |   |   |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>MD</b>   | 10b. County<br><b>MONTGOMERY</b>  | 10c. City, Town or Location<br><b>SILVER SPRING</b>   |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |
|   | 10e. Street and Number<br><b>11700 OLD COLUMBIA PIKE, #404</b>  |   |   | 10f. Zip Code<br><b>20904</b>  |  | 10g. Citizen of What Country?<br><b>UNITED STATES</b>   |   |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b> |  |
|   | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>TAILOR</b>   |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>CLOTHING</b>                       |  | 16b. Kind of Business/Industry   |   |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>MARVIN JOSEPH FRANKEL</b>   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>SARA RACHEL GOLDENZWEIG</b>  |  |   |   |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><b>MARILYN LAND, DAUGHTER</b>   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>10912 LOMBARDY ROAD, SILVER SPRING, MD 20901</b> |  |   |   |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>KING DAVID MEM. GARDEN</b>   |  | Date   | 20c. Location - City or Town, State<br><b>FALLS CHURCH, VIRGINIA</b>  |   |  |
|   | 21. Signature of Funeral Service Licensee<br>   |   | 22. Name and Address of Facility<br><b>DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.<br/>1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852</b>                     |  |  |   |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |   |  |  |   |   | Approximate Interval Between Onset and Death |
|   | Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Arteriosclerotic Heart Disease</b> years<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  |  |   |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |   |  |
|   |   |   |   |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |
|   |   |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |   |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |   | 28a. Date of Injury (Month, Day Year)   | 28b. Time of Injury<br>M  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   | 28d. Describe how injury occurred  |   |   |  |
|   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |   |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |   |  |  |   |   |  |
| 29b. Signature and title of certifier<br>  |   |   | 29c. License number<br><b>D08 546</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>Feb. 3. 96</b>   |   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JOHN F. TAUBER, M.D., 8218 WISCONSIN AVENUE, #318 BETHESDA, MD 20814</b>   |   |   |   |  |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 05 1996</b>   |   | 32. Registrar's Signature<br>  |   |  |  |   |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04965

|   |  |  |  |   |  |  |  |   |  |
|---|--|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>JUNIOR D. GUINN   |  |  |  | 2. DATE OF DEATH<br>February 5 1996<br>MONTH DAY YEAR   |  |  |  | 3. TIME OF DEATH<br>14:30 P M   |  |
| 4. SOCIAL SECURITY NUMBER<br>223-70-6928  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>43 YRS.   |  | 7. DATE OF BIRTH<br>Feb. 1 1953<br>(Month, Day, Year)                                |  | 8. BIRTHPLACE (State or Foreign Country)<br>Garrett County  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Sacred Heart Hospital   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Cumberland   |  |  |  | 9c. COUNTY OF DEATH<br>Allegany   |  |
| 10a. STATE<br>Maryland  |  | 10b. COUNTY<br>Allegany  |  | 10c. CITY, TOWN OR LOCATION<br>Cumberland   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br>12116-A McMullen Highway  |  |  |  | 10f. ZIP CODE<br>21502  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>United States  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |  |  | 14. RACE — American Indian, Black, Wtite, etc.<br>Specify: White  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>Unknown  |  | 15b. COLLEGE (1-4 or 5+)<br>College (1-4 or 5+)  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>None   |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>None  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Joseph E. Guinn  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Eva Mae Dye  |  |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Sandra Guinn  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>12116-A McMullen Highway, Cumberland, Md. 21502  |  |  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Rocky Gap Veterans C. 2-8-96  |  |   |  | 20c. LOCATION — City or Town, State<br>Flintstone, Md.                               |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Wayne Boal   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Boal Funeral Home<br>111 Church St. Westernport, Md.  |  |  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ventricular arrhythmic<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. cardiomyopathy<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. atherosclerotic cardiovascular disease<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Approximate Interval Between Onset and Death<br>5 min<br>10 yrs<br>15 yrs |  |  |  |   |  |  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>asthma  |  |  |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  |   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Donald F. Manger M.D.   |  |   |  |  |  |   |  |
| 29c. LICENSE NUMBER<br>009231   |  | 29d. DATE SIGNED (Month, Day, Year)<br>2/6/96  |  |   |  |  |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Donald F. Manger, M.D. 11600 Bedford Road, Cumberland, MD 21502  |  |  |  |   |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>FEB 07 1996  |  | 32. REGISTRAR'S SIGNATURE<br>John Anderson   |  |   |  |  |  |   |  |





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR   |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 96 04966  |  |
|---|--|--|--|---|--|---|--|---|--|
| CERTIFICATE OF DEATH  |  |  |  | REG. NO.  |  |   |  |   |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MILDRED W. GREEN</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Feb. 4, 1996</b>   |  |   |  | 3. TIME OF DEATH<br><b>8:17 P M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>213-24-0114</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br><b>95</b> YRS. | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS.<br>HOURS MIN.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>FEB. 4, 1901</b>                                      |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>102 CHURCH STREET</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>MARDELA SPRINGS</b>   |  |   |  | 9c. COUNTY OF DEATH<br><b>WICOMICO</b>  |  |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |   |  |   |  |
| 10a. STATE<br><b>MD.</b>  |  | 10b. COUNTY<br><b>WICOMICO</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>MARDELA SPRINGS</b>   |  |   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10a. STREET AND NUMBER<br><b>102 CHURCH STREET</b>  |  |  |  | 10f. ZIP CODE<br><b>21837</b>   |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR OATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                         |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b><br>College (1-4 or 5+) <b>College</b>  |  | 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>HOMEMAKER</b>   |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>OWN HOME</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>ISAAC JAMES WRIGHT</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>SALLIE BEACH</b>  |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>CATHERINE SCHAFER</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>200 CHURCH ST., MARDELA SPRINGS, MD. 21837</b>  |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>MARDELA MEM. CEMETERY</b>  |  | DATE<br><b>2/7</b>  |  | 20c. LOCATION — City or Town, State<br><b>MARDELA SPRINGS, MD.</b>                          |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Gerald C. Bounds</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>BOUNDS FUNERAL HOME, SALISBURY, MARYLAND</b>   |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Congestive heart failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <b>Coronary artery disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Approximate Interval Between Onset and Death<br><b>&gt; 2 yrs</b><br><b>&gt; 2 yrs</b> |  |  |  |   |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/></b>  |  |  |  |   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> A <input type="checkbox"/> P <input type="checkbox"/> N   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Stephan Pavlov</i> MD   |  |  |  | 29c. LICENSE NUMBER<br><b>D 41721</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>2/6/96</b>  |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>STEPHAN PAVLOV 560 RIVERSIDE DR SALISBURY MD 21801</b>  |  |  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 06 1996</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John D. ...</i>   |  |   |  |   |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 96 04967

|  |   |                          |   |  |  |   |  |  |   |  |
|--|---|--------------------------|---|--|--|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Helen (nmn) Grant                               |                          |   |  |  |   | 2. Date of Death<br>Month Day Year<br>February 4, 1996   |  | 3. Time of Death<br>0550                                  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Harford Memorial Hospital |                          |   |  |  |   | 4b. City, Town, or Location of Death<br>Havre de Grace   |  | 4c. County of Death<br>Harford                            |  |
| Funeral<br>Director  | 5. Social Security Number<br>232-32-0082  |                          | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>72 Yrs.  |   | 8. Date of Birth (Month, Day, Year)<br>July 16, 1923     |  | 9. Birthplace (State or Foreign Country)<br>West Virginia |  |
|  | Usual Residence of Decedent   |                          |   |  |  |   |  |  |   |  |
| 10a. State<br>Maryland   |   | 10b. County<br>Harford   |   | 10c. City, Town or Location<br>Edgewood  |  |   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   |  |
| 10e. Street and Number<br>2503 Willoughby Beach Road   |   |                          |   | 10f. Zip Code<br>21040   |  | 10g. Citizen of What Country?<br>USA  |  |  |   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   |                          | 12. Was Decedent Ever In U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: white                                   |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 9<br>College (1-4or 5+)   |   |                          |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker |  |   | 16b. Kind of Business/Industry<br>Home                   |  |   |  |
| 17. Father's Name (First, Middle, Last)<br>John (nmn) Mudd   |   |                          |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Annie (nmn) Globus   |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Stephen H. Grant   |   |                          |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2503 Willoughby Beach Road, Edgewood, Md. 21040  |  |  |   |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   |                          | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Mt. Zion Cemetery   |  | Date<br>2/7/96   |   | 20c. Location - City or Town, State<br>Bel Air, Maryland |  |   |  |
| 21. Signature of Funeral Service Licensee<br>Stephen A. Hughes   |   |                          |   |  |  | 22. Name and Address of Facility<br>Howard K. McComas III Funeral Home, P.A.<br>1317 Cokesbury Road, Abingdon, Md. 21009  |  |  |   |  |
| 23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. Exacerbation chronic obstructive Pulmonary Disease & Asthma<br>Due to (or as a consequence of):<br>b. Acute bronchitis / oxygen dependent<br>Due to (or as a consequence of):<br>c. Congestive heart failure<br>Due to (or as a consequence of):<br>d. Atherosclerotic Cardiovascular Disease<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |                          |   |  |  |   |  |  |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |   |                          |   |  |  | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |                          |   |  |  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |   |  |
| 26. Place of Death (Check only one)<br>Hospice: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |   |                          |   |  |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |  |  |   |  |
| 28a. Date of Injury (Month, Day, Year)   |   | 28b. Time of Injury<br>M |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                   |  | 28d. Describe how injury occurred   |  |  |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |                          |   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |                          |   |  |  |   |  |  |   |  |
| 29b. Signature and title of certifier<br>Bryg  |   |                          |   | 29c. License number<br>D43115  |  | 29d. Date signed (Month, Day, Year)<br>2-4-96   |  |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)   |   |                          |   |  |  |   |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br>FEB 5 1996  |   |                          |   |  |  | 32. Registrar's Signature<br>John Davidson Randall  |  |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR   |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 96 04968  |  |   |  |
|--|--|--|--|--|--|--|--|---|--|---|--|
| CERTIFICATE OF DEATH   |  |  |  | REG. NO.   |  |  |  |   |  |   |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Marian Elizabeth Gordon  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>February 3, 1996   |  |  |  | 3. TIME OF DEATH<br>11:08 A M   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br>579-86-3722   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>81 YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>July 13, 1914                                 |  | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>St. Mary's Hospital  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Leonardtwn  |  |  |  | 9c. COUNTY OF DEATH<br>St. Mary's   |  |   |  |
| RESIDENCE OF DECEDENT  |  |  |  |  |  |  |  |   |  |   |  |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>St. Mary's  |  | 10c. CITY, TOWN OR LOCATION<br>Piney Point   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO       |  |   |  |
| 10e. STREET AND NUMBER<br>P.O. Box 104   |  |  |  | 10f. ZIP CODE<br>20674   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                                       |  |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>8th Grade  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Homemaker  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Own Home  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>John W. Henderson   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Annie Roberta Thompson  |  |  |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Christine M. Rock  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>P.O. Box 104, Piney Point, MD 20674   |  |  |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Washington National Cem. 2/6/96                               |  | 20c. LOCATION — City or Town, State<br>Suitland Maryland   |  |  |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Michael H. Gardiner</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Mattingley-Gardiner Funeral Home, P.A.<br>P.O. Box 270, Leonardtown, Maryland 20650  |  |  |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Acute Coronary Arterial Disease</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |  |  |  |  | Approximate interval Between Onset and Death  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  |  |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  | 29c. LICENSE NUMBER<br>D25230  |  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br>2/5/96   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>DAVID ALLEN, Box 601 Leonardtown MD 20650   |  |  |  |  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>FEB -6 1996   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John A. ...</i>  |  |  |  |   |  |   |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 96 04969

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) (Helen Bertha Granzow)  
2. Date of Death Month Day Year January 31, 1996  
3. Time of Death 1 P

4a. Facility Name (If not institution, give street and number) Prince George's Hospital Center  
4b. City, Town, or Location of Death Cheverly  
4c. County of Death Prince George's

Funeral  
Director

5. Social Security Number 578-20-0217  
6. Sex 1 ☐ M 2 ☒ F  
7. Age (In yrs. last birthday) 72 Yrs.  
8. Date of Birth (Month, Day, Year) May 19, 1923  
9. Birthplace (State or Foreign Country) Maryland

Usual Residence of Decedent  
10a. State Maryland  
10b. County Prince George's  
10c. City, Town or Location Mount Rainier  
10d. Inside City Limits 1 ☒ Yes 2 ☐ No

10e. Street and Number 3400 Shepherd Street  
10f. Zip Code 20712  
10g. Citizen of What Country? U.S.A.

11. Marital Status 1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced  
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:  
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:  
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nurses Aid  
16b. Kind of Business/Industry Sacred Heart Home

17. Father's Name (First, Middle, Last) Antoine Rolfes  
18. Mother's Name (First, Middle, Maiden Surname) Helen Knopp

19a. Informant's Name/Relationship (Type, Print) Karl Granzow / Son  
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4204 32nd Street, Mount Rainier, Maryland 20712

20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)  
20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Cemetery 2/03/1996  
20c. Location - City or Town, State Brentwood, Maryland

21. Signature of Funeral Service Licensee  
22. Name and Address of Facility Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. List only one cause on each line.  
23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Immediate Cause (Final disease or condition resulting in death) Hypertensive cardiovascular disease  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  
Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Emphysema, Atherosclerosis  
24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No  
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No  
26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined  
28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 ☐ Yes 2 ☐ No  
28d. Describe how injury occurred  
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier  
29c. License number  
29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ambush P. Rodriguez MD, 5009 Rayburn Ct Ep Spr Md 2074

31. Date Filed (Month, Day, Year) FEB 05 1996  
32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

1-2-7-8-9-10-11-12-13-14-15-16-17-18-19-20-21-22-23-24-25-26-27-28-29-30-31-32-33-34-35-36-37-38-39-40-41-42-43-44-45-46-47-48-49-50-51-52-53-54-55-56-57-58-59-60-61-62-63-64-65-66-67-68-69-70-71-72-73-74-75-76-77-78-79-80-81-82-83-84-85-86-87-88-89-90-91-92-93-94-95-96-97-98-99-100-101-102-103-104-105-106-107-108-109-110-111-112-113-114-115-116-117-118-119-120-121-122-123-124-125-126-127-128-129-130-131-132-133-134-135-136-137-138-139-140-141-142-143-144-145-146-147-148-149-150-151-152-153-154-155-156-157-158-159-160-161-162-163-164-165-166-167-168-169-170-171-172-173-174-175-176-177-178-179-180-181-182-183-184-185-186-187-188-189-190-191-192-193-194-195-196-197-198-199-200-201-202-203-204-205-206-207-208-209-210-211-212-213-214-215-216-217-218-219-220-221-222-223-224-225-226-227-228-229-230-231-232-233-234-235-236-237-238-239-240-241-242-243-244-245-246-247-248-249-250-251-252-253-254-255-256-257-258-259-260-261-262-263-264-265-266-267-268-269-270-271-272-273-274-275-276-277-278-279-280-281-282-283-284-285-286-287-288-289-290-291-292-293-294-295-296-297-298-299-300-301-302-303-304-305-306-307-308-309-310-311-312-313-314-315-316-317-318-319-320-321-322-323-324-325-326-327-328-329-330-331-332-333-334-335-336-337-338-339-340-341-342-343-344-345-346-347-348-349-350-351-352-353-354-355-356-357-358-359-360-361-362-363-364-365-366-367-368-369-370-371-372-373-374-375-376-377-378-379-380-381-382-383-384-385-386-387-388-389-390-391-392-393-394-395-396-397-398-399-400-401-402-403-404-405-406-407-408-409-410-411-412-413-414-415-416-417-418-419-420-421-422-423-424-425-426-427-428-429-430-431-432-433-434-435-436-437-438-439-440-441-442-443-444-445-446-447-448-449-450-451-452-453-454-455-456-457-458-459-460-461-462-463-464-465-466-467-468-469-470-471-472-473-474-475-476-477-478-479-480-481-482-483-484-485-486-487-488-489-490-491-492-493-494-495-496-497-498-499-500-501-502-503-504-505-506-507-508-509-510-511-512-513-514-515-516-517-518-519-520-521-522-523-524-525-526-527-528-529-530-531-532-533-534-535-536-537-538-539-540-541-542-543-544-545-546-547-548-549-550-551-552-553-554-555-556-557-558-559-560-561-562-563-564-565-566-567-568-569-570-571-572-573-574-575-576-577-578-579-580-581-582-583-584-585-586-587-588-589-590-591-592-593-594-595-596-597-598-599-600-601-602-603-604-605-606-607-608-609-610-611-612-613-614-615-616-617-618-619-620-621-622-623-624-625-626-627-628-629-630-631-632-633-634-635-636-637-638-639-640-641-642-643-644-645-646-647-648-649-650-651-652-653-654-655-656-657-658-659-660-661-662-663-664-665-666-667-668-669-670-671-672-673-674-675-676-677-678-679-680-681-682-683-684-685-686-687-688-689-690-691-692-693-694-695-696-697-698-699-700-701-702-703-704-705-706-707-708-709-710-711-712-713-714-715-716-717-718-719-720-721-722-723-724-725-726-727-728-729-730-731-732-733-734-735-736-737-738-739-740-741-742-743-744-745-746-747-748-749-750-751-752-753-754-755-756-757-758-759-760-761-762-763-764-765-766-767-768-769-770-771-772-773-774-775-776-777-778-779-780-781-782-783-784-785-786-787-788-789-790-791-792-793-794-795-796-797-798-799-800-801-802-803-804-805-806-807-808-809-810-811-812-813-814-815-816-817-818-819-820-821-822-823-824-825-826-827-828-829-830-831-832-833-834-835-836-837-838-839-840-841-842-843-844-845-846-847-848-849-850-851-852-853-854-855-856-857-858-859-860-861-862-863-864-865-866-867-868-869-870-871-872-873-874-875-876-877-878-879-880-881-882-883-884-885-886-887-888-889-890-891-892-893-894-895-896-897-898-899-900-901-902-903-904-905-906-907-908-909-910-911-912-913-914-915-916-917-918-919-920-921-922-923-924-925-926-927-928-929-930-931-932-933-934-935-936-937-938-939-940-941-942-943-944-945-946-947-948-949-950-951-952-953-954-955-956-957-958-959-960-961-962-963-964-965-966-967-968-969-970-971-972-973-974-975-976-977-978-979-980-981-982-983-984-985-986-987-988-989-990-991-992-993-994-995-996-997-998-999-1000-1001-1002-1003-1004-1005-1006-1007-1008-1009-1010-1011-1012-1013-1014-1015-1016-1017-1018-1019-1020-1021-1022-1023-1024-1025-1026-1027-1028-1029-1030-1031-1032-1033-1034-1035-1036-1037-1038-1039-1040-1041-1042



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO.  |
|---|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>David A. Gaskins</b>   |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>February 1, 1996</b>            |   |
| 3. TIME OF DEATH<br><b>11 A.M.</b>  |  |  |  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>577-52-4995</b>   | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday)<br><b>57 YRS.</b>   | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>March 2, 1938</b>           |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Washington, D.C.</b>   |  |  |  |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>200 Fort Meade Rd. #605</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Laurel</b>   |  | 9c. COUNTY OF DEATH<br><b>Prince George's</b>   |
| RESIDENCE OF DECEDENT   |  |  |  |   |
| 10a. STATE<br><b>Maryland</b>   | 10b. COUNTY<br><b>Prince George's</b>                                      | 10c. CITY, TOWN OR LOCATION<br><b>Laurel</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |
| 10e. STREET AND NUMBER<br><b>200 Fort Meade Road Apt. #605</b>  |  | 10f. ZIP CODE<br><b>20707</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMY FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |
| 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>   |  |  |  |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12th grade</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Driver</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Dept. Of Transportation</b>  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Hampton T. Gaskins</b>  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Coral Wilson</b> |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mrs. Margaret R. Gaskins (Wife)</b>  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>200 Fort Meade Road Apt. #605 Laurel, Maryland 20707</b>   |  |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>National Harmony Memorial Park 2/5/96 Landover, Maryland</b>   |  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Rollins Funeral Home, Inc.<br/>4339 Hunt Place, N.E. Washington, D.C. 20019</b>   |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Metastatic squamous cell cancer of hypopharynx.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  | Approximate Interval Between Onset and Death<br><b>6 months</b>   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   | 28b. TIME OF INJURY<br><b>M</b>  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |
| 28d. DESCRIBE NOW INJURY OCCURRED   |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Raymond E. Banfer MD</b>  |  | 29c. LICENSE NUMBER<br><b>D36371</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>Feb. 1, 1996</b>  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>RAYMOND E. BANFER MD 8105 L ALL SAINTS RD, LAUREL, MD 20723</b>   |  |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 05 1996</b>   |  | 32. REGISTRAR'S SIGNATURE<br>   |  |   |



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR   |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 96 04971  |  |   |  |
|---|--|--|--|--|--|--|--|---|--|---|--|
| CERTIFICATE OF DEATH  |  |  |  | REG. NO.   |  |  |  |   |  |   |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Marian J. Grayson</i>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><i>January 30, 1996</i>  |  |  |  | 3. TIME OF DEATH<br><i>10:40A</i>   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><i>251-28-4129</i>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><i>72</i> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><i>Nov. 13, 1923</i>                      |  | 8. BIRTHPLACE (State or Foreign Country)<br><i>Brooklyn, N.Y.</i>                                     |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>DOCTORS COMMUNITY HOSPITAL</i>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Lanham</i>   |  |  |  | 9c. COUNTY OF DEATH<br><i>Prince George's</i>   |  |   |  |
| RESIDENCE OF DECEDENT   |  |  |  |  |  |  |  |   |  |   |  |
| 10a. STATE<br><i>Maryland</i>   |  | 10b. COUNTY<br><i>Prince Georges</i>   |  | 10c. CITY, TOWN OR LOCATION<br><i>Greenbelt</i>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO       |  |   |  |
| 10e. STREET AND NUMBER<br><i>5811 Cherrywood Lane #203</i>  |  |  |  | 10f. ZIP CODE<br><i>20770</i>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>United States</i>   |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><i>Negro</i>                            |  |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>4</i> College (1-4 or 5+) <i>4</i>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><i>Housewife and Teacher</i>   |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>State Government</i>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Eliot J. Johnson</i>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Mahala Crump</i>   |  |  |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Robin S. Daniels - Daughter</i>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>4646 Minnesota Avenue, N.E., Washington, D. C.</i>   |  |  |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Fort Lincoln Cemetery</i>                              |  | DATE<br><i>2/3/96</i>  |  | 20c. LOCATION — City or Town, State<br><i>Brentwood, Maryland</i>                |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>John T. Stewart III</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>STEWART FUNERAL HOME, Inc.<br/>4001 Benning Road, N.E., Washington, D.C.</i>  |  |  |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>CARCINOMATOSIS</i><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. <i>CARCINOMA OF THE LUNG</i><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |  |  |  |  | Approximate Interval Between Onset and Death  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  |  |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> 1 <input type="checkbox"/> YES <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: In the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Michael Sigm MD</i>  |  |  |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>1/31/96</i>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>MEHDI FARZANI 7525 Greenway CTR DR Greenbelt 20770</i>  |  |  |  |  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><i>FEB 06 1996</i>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Andrew Harrell</i>  |  |  |  |   |  |   |  |

10-11-68

10-11-68

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10-11-68

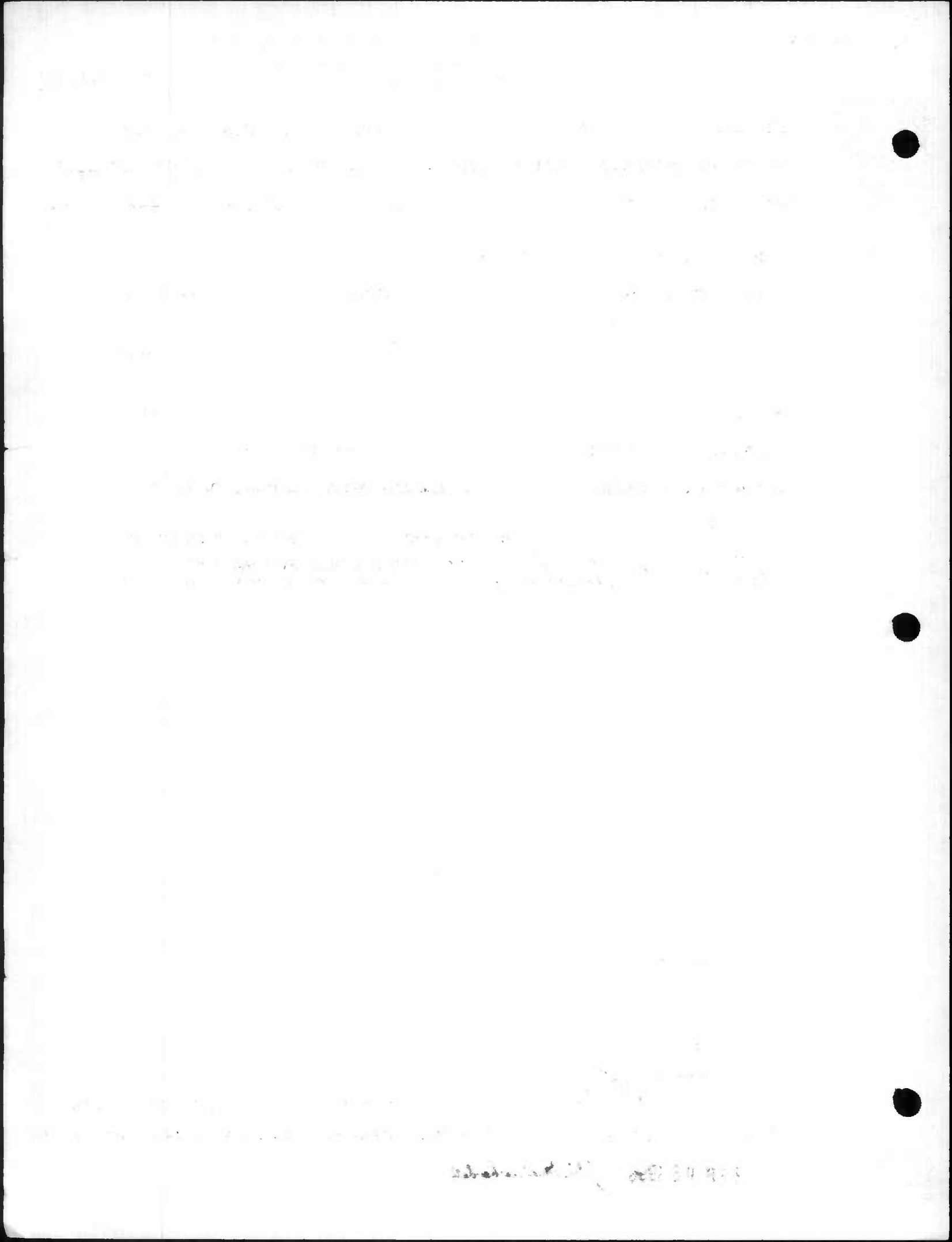
10-11-68

10-11-68

|  |   |   |   |  |  |
|--|---|---|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>TREVOUR J. GAY</b>   |   | 2. Date of Death<br>Month Day Year<br><b>FEBRUARY 6, 1996</b>   |  | 3. Time of Death<br><b>1:02 P.M.</b>   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>SOUTHERN MARYLAND HOSPITAL CENTER</b>  |   | 4b. City, Town, or Location of Death<br><b>CLINTON</b>  |  | 4c. County of Death<br><b>PRINCE GEORGES</b>   |
| Funeral<br>Director  | 5. Social Security Number<br><b>217-45-6858</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>Yrs. <b>2</b> Months <b>14</b> Days   | 8. Date of Birth (Month, Day, Year)<br><b>11-23-95</b>                           | 9. Birthplace (State or Foreign Country)<br><b>WASH., D. C.</b>                                |
|  | Usual Residence of Decedent   |   |   |  |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>MD</b>   | 10b. County<br><b>P. G.</b>   | 10c. City, Town or Location<br><b>CLINTON</b>   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
|  | 10e. Street and Number<br><b>7306 PACELLA COURT</b>   |   | 10f. Zip Code<br><b>20735</b>   |  | 10g. Citizen of What Country?<br><b>U. S. A.</b>   |
|  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>                        |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>N. A.</b> College (1-4or 5+) <b>N. A.</b>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>N. A.</b>   |  | 16b. Kind of Business/Industry<br><b>N. A.</b>   |
| To Be Completed by Physician/Medical Examiner  | 17. Father's Name (First, Middle, Last)<br><b>TERENCE BARKER</b>  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>LA TONIA GAY</b>  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>LA TONIA GAY - MOTHER</b>  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7306 PACELLA COURT CLINTON, MD 20735</b>  |  |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>LEE CREMATORY</b>  | Date<br><b>2/7/96</b>   | 20c. Location - City or Town, State<br><b>CLINTON. MD</b>                        |  |
|  | 21. Signature of Funeral Service Licensee<br><i>Theodore C. Pinckney</i>  |   | 22. Name and Address of Facility<br><b>PINCKNEY-SPANGLER FUNERAL HOME</b><br><b>524 - 8TH ST., N. E. WASH., D. C. 20002</b>   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>SUDDEN INFANT DEATH SYNDROME (SIDS)</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of): |   |   |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |   |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |   |   |  |  |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |   |   |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |   |   |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input checked="" type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)   | 28b. Time of Injury<br><b>M</b>   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | 28d. Describe how injury occurred  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   | 29b. Signature and title of certifier<br><i>[Signature]</i>   |   | 29c. License number<br><b>O.C.M.E.</b>   | 29d. Date signed (Month, Day, Year)<br><b>FEBRUARY 7, 1996</b>                                 |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>David R Fowler 111 Penn Street, Baltimore, Maryland 21201</b>   |   |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 08 1996</b>  |   | 32. Registrar's Signature<br><i>[Signature]</i>   |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04973

1 0/1

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

|  |  |  |  |   |  |   |   |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>James Aloysius Gordon</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>February</b> DAY <b>5</b> , 1996 YEAR  |  | 3. TIME OF DEATH<br><b>11:29A</b> M   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>217-28-8200</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br><b>63</b> YRS. | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Dec. 20, 1933</b>   |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Leonardtwn, MD</b>                               |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Doctor's Hospital</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Lanham, Maryland</b>  |  | 9c. COUNTY OF DEATH<br><b>Prince Georges</b>  |   |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Prince Georges</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Palmer Park, Maryland</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><b>7619 Greenleaf Road</b>   |  |  |  | 10f. ZIP CODE<br><b>20785</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |   |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>                         |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b><br>College (1-4 or 5+) <b>College</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Maintenance</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Private</b>  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Carter Gordon</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mary Catherine Young</b>  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mary E. Holley/Sister</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7619 Greenleaf Road Palmer Park, Maryland 20785</b>                                       |  |   |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Harmony Memorial Park 2/10</b>   |  | 20c. LOCATION — City or Town, State<br><b>Landover, Maryland</b>  |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Alexander S. Pope</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Alexander S. Pope Funeral Homes<br/>2617 Penn Ave SE Washington, DC 20020</b>  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CARDIAC ASYSTOLE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>RESPIRATOR FAILURE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>END STAGE COPD</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>PNEUMONIA</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |  |  |   |  |   | Approximate Interval Between Onset and Death<br><b>&lt; 1-hour</b><br><b>&gt; 6-month</b>   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>pneumothorax, sepsis, H0-CVA, pulmonary embolism</b>  |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>  |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                |   |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                    |   |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>  |  |  |  | 29c. LICENSE NUMBER<br><b>D-34525</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>02-05-96</b>  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 2) (Type, Print)<br><b>S-J Rao, MD; 4000-Mitchellville Road; #220; Bowie, MD 20716</b>   |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 09 1996</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |   |   |





Amended #7, 2/6/96, MRT, Montgomery County  
 FOR  
 STATE  
 REGISTRAR  
 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH  
 REG. NO.

96 04974

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Nancy L. Grost</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 14 1996</b>  |  | 3. TIME OF DEATH<br><b>12:15 P.M.</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>456-64-6712</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>53</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Sept. 14, 1942</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Texas</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Laurel Regional Hospital</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Laurel</b>  |  |
| 9c. COUNTY OF DEATH<br><b>Prince Georges</b>  |  |  |  | 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Montgomery</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Silver Spring</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>14547 Kelmscot Drive</b>   |  |
| 10f. ZIP CODE<br><b>20906</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                                |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+) <b>2</b>  |  | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Own Home</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Charles Wesley Milligan</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mollie Kissner</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Allison F. Sanders</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P.O. Box 201, Warrenton, Missouri 63383</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Norbeck Memorial Park</b>  |  | 20c. LOCATION — City or Town, State<br><b>Olney, Maryland</b>   |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Barbara Jo McMullen Lawrence</b> M00831                   |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805</b>  |  |  |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Pneumonia with Sepsis</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>DUE TO (OR AS A CONSEQUENCE OF):<br>DUE TO (OR AS A CONSEQUENCE OF):<br>DUE TO (OR AS A CONSEQUENCE OF):<br>DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  | Approximate Interval Between Onset and Death<br><b>14 days</b>  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Diabetes Mellitus</b><br><b>Paraparesis due to Multiple Sclerosis</b><br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |   |  |   |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |  |   |  |   |  |
| 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Michael Berard, M.D.</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D26214</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>1/14/96</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Michael Berard, M.D. 7305 Baltimore Ave #107, College Park, MD 20740</b>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 06 1996</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |  |  |  |  |   |  |
|--|--|---|--|--|--|--|--|---|--|
| CERTIFICATE OF DEATH   |  |   |  |  |  |  |  |   |  |
| REG. NO.   |  |   |  |  |  |  |  |   |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ANNA E. GRIFFIN</b>   |  |   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>01</b> DAY <b>28</b> YEAR <b>96</b>                     |  | 3. TIME OF DEATH<br><b>8:59</b> M   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>577-44-9293</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>87</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Dec. 23, 1908</b>                          |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>West Virginia</b>                                    |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Holy Cross Hospital</b>   |  |   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Silver Spring</b>                          |  | 9c. COUNTY OF DEATH<br><b>Montgomery</b>  |  |
| RESIDENCE OF DECEDENT  |  |   |  |  |  |  |  |   |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Montgomery</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Rockville</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>4603 Mercury Drive</b>  |  |   |  | 10f. ZIP CODE<br><b>20853</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>              |  |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>3</b> College (1-4 or 5+) <b>3</b>   |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Registered Nurse</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Health Care</b>                                 |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Luke J. Casey</b>  |  |   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Elizabeth B. Rowan</b>       |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Elizabeth C. Giglioli</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4603 Mercury Drive, Rockville, MD 20853</b>  |  |  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Gate of Heaven Cemetery 2/1/96</b>  |  | DATE<br><b>2/1/96</b>  |  | 20c. LOCATION — City or Town, State<br><b>Silver Spring, MD</b>                      |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Robert E. Ramsey</i>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Francis J. Collins Funeral Home, Inc.<br/>500 University Blvd.W. Sil.Spr.MD 20901</b>   |  |  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |  |  |  |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiac arrest</b>  |  |   |  |  |  |  |  |   |  |
| a. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |  |  |  |  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  |   |  |  |  |  |  |   |  |
| b. DUE TO (OR AS A CONSEQUENCE OF): <b>Coronary artery disease</b>   |  |   |  |  |  |  |  |   |  |
| c. DUE TO (OR AS A CONSEQUENCE OF): <b>Atherosclerosis</b>   |  |   |  |  |  |  |  |   |  |
| d.   |  |   |  |  |  |  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Surgical amputation right leg.</b>  |  |   |  |  |  |  |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |   |  |  |  |  |  |   |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |   |  |  |  |  |  |   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>  |  |   |  |  |  |  |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |  |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>  |  |   |  |  |  | 29c. LICENSE NUMBER<br><b>DO 2338</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>1/29/96</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>RICHARD P. DELANEY, MD 9801 GEORGIA AVE., SILVER SPRING, MD 20902</b>  |  |   |  |  |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 05 1996</b>  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Anderson-Randall</i>   |  |  |  |  |  |   |  |



TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR   |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 96 04976   |  |
|---|--|--|--|--|--|--|--|--|--|
| CERTIFICATE OF DEATH  |  |  |  | REG. NO.   |  |  |  |  |  |
| 1. DECEASED'S NAME (First, Middle, Last)<br><b>Berkeley E. Grove</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>February</b> DAY <b>7</b> YEAR <b>1996</b>  |  |  |  | 3. TIME OF DEATH<br><b>10:10 A.M.</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>577-42-5392</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br><b>69</b> YRS. | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>   |  | IF UNDER 24 HRS.<br>HOURS <b></b> MIN. <b></b>                         |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>February 12, 1926</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Greater Laurel Regional Hospital</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Laurel</b>   |  |  |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>West Virginia</b>   |  |
| RESIDENCE OF DECEDENT   |  |  |  |  |  |  |  |  |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Montgomery</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Laurel</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br><b>3909 Blackburn Lane #12</b>  |  |  |  | 10f. ZIP CODE<br><b>20866</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 6</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Exterminator</b>         |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Colleys Exterminating</b>   |  |  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Berkeley E. Grove, Sr.</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Ella (Unobtainable)</b>  |  |  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>David Grove</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2105 Serpentine Ter., Silver Spring, MD 20904</b>  |  |  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Greenhill Cemetery</b>                                 |  | DATE<br><b>1-10-96</b>   |  | 20c. LOCATION — City or Town, State<br><b>Martinsburg, W. Virginia</b> |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Alan J. Donnell</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Hines-Rinaldi Funeral Home, Inc. 20904<br/>11800 New Hampshire Ave., Silver Spring, MD</b>  |  |  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b><br><b>a. Acute Myocardial Infarction</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. Severe Coronary and Peripheral Vascular Disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c. Atherosclerosis</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d. Necrotizing Fascitis, right lower leg</b> |  |  |  |  |  |  |  | Approximate Interval Between Onset and Death   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>① Diabetes mellitus</b><br><b>② Persistent Wound</b><br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |  |  | 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  |
| 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Dr. Joselito D. Magday</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D13687</b>   |  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>2-7-96</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Dr. Joselito D. Magday, 11701 Roby Ave., Beltsville, MD 20705</b>   |  |  |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 09 1996</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>John A. Hudson</b>   |  |  |  |  |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04977

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

John Galvins

2. Date of Death

Month

Day

Year

January 3, 1996

3. Time of Death

153 PM

4a. Facility Name (If not institution, give street and number)

802 Larch Avenue

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Prince Georges

Funeral  
Director

5. Social Security Number

577-46-2019

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Nov. 22, 1926

9. Birthplace (State or Foreign Country)

Latvia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince Georges

10c. City, Town or Location

Takoma Park

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

802 Larch Avenue

10f. Zip Code

20912

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Printing

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Martins Galvins

18. Mother's Name (First, Middle, Maiden Surname)

Maria Martinsons

19a. Informant's Name/Relationship (Type, Print)

Olga Galvins

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1440 Aspen Street, N.W. Washington, D.C. 20012

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory 2/5/96

Date

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

Francis J. Collins Funeral Home, Inc.

22. Name and Address of Facility

500 University Blvd., W. Sil. Spr., MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Hypertensive arteriosclerotic cardiovascular disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

She used powder

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

August P. Rodriguez MD

29c. License number

B21230

29d. Date signed (Month, Day, Year)

February 4, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

August P. Rodriguez MD, 500 University Blvd. Sp. Md 20748

31. Date filed (Month, Day, Year)

FEB 05 1996

32. Registrar's Signature

John Andrew Randall

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

|   |  |  |  |  |  |   |  |  |  |
|---|--|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 96 04978  |  |  |  |
| CERTIFICATE OF DEATH  |  |  |  | REG. NO.   |  |   |  |  |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br>ANNA GORODETSKAYA   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>JANUARY 30 1996  |  | 3. TIME OF DEATH<br>9:05 P M  |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br>220-35-3319  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>84 YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>Nov. 24, 1911  |  |  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Russia  |  |  |  | 9. COUNTRY OF DEATH<br>Russia  |  |   |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Shady Grove Hospital  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Rockville, MD   |  | 9c. COUNTY OF DEATH<br>Montgomery   |  |  |  |
| 10a. STATE<br>MD  |  |  |  | 10b. COUNTY<br>Montgomery  |  | 10c. CITY, TOWN OR LOCATION<br>Rockville  |  |  |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |  |  |   |  |  |  |
| 10e. STREET AND NUMBER<br>5509 Halpine Place  |  |  |  | 10f. ZIP CODE<br>20851   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>Russia   |  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White  |  |  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>4   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Teacher  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Government   |  |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Schachna Gorodetskiy   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Tanya Viner   |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Susan Schaner   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>8224 Windsor View Terr., Rockville, MD 20854  |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Judean Memorial Gardens 2/4   |  | 20c. LOCATION — City or Town, State<br>Olney, MD   |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL DIRECTOR LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Edward Sagel Funeral Direction<br>1091 Rockville Pike Rockville, MD 20852  |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Carcinomatous meningitis</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <u>Lymphoma</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |  |  |   |  | Approximate Interval Between Onset and Death<br><u>minutes</u><br><u>10 days</u>   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>   |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                      |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><u>Mary Fay, MD</u>  |  |  |  | 29c. LICENSE NUMBER<br><u>D23448</u>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><u>February 1, 1996</u>  |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><u>Mary Fay, MD 121 Congressional La., Rockville, MD 20852</u>   |  |  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><u>FEB 06 1996</u>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><u>Julia Anderson Randall</u>   |  |   |  |  |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04979

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

RONALD S. GOLDBERG

2. Date of Death

February 03 1996

3. Time of Death

03:45 AM

4a. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

ROCKVILLE

MONTGOMERY

Funeral  
Director

5. Social Security Number

578-42-0369

6. Sex

XXM 2 ☐ F

7. Age (In yrs. last birthday)

63 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

SEPT. 13, 1932 WASHINGTON, DC

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

MONTGOMERY

10c. City, Town or Location

GAITHERSBURG

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

821 INSPIRATION LANE

10f. Zip Code

20878

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

ATTORNEY

16b. Kind of Business/Industry

LAW

17. Father's Name (First, Middle, Last)

ABRAHAM GOLDBERG

18. Mother's Name (First, Middle, Maiden Surname)

FLORENCE ZARITSKY

19a. Informant's Name/Relationship (Type, Print)

SALLY GOLDBERG (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

821 INSPIRATION-GAITHERSBURG, MD 20878

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

KING DAVID

Date

2-4-96

20c. Location - City or Town, State

FALLS CHURCH, VIRGINIA

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

DANZANSKY-GOLDBERG MEMORIAL CHAPELS INC.  
1170 ROCKVILLE PIKE-ROCKVILLE, MD 20852

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CHRONIC LYMPHOBLASTIC LEUKEMIA

Two years

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

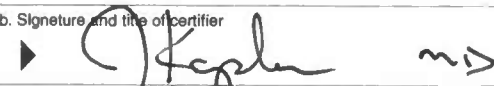
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D 35635

29d. Date signed (Month, Day, Year)

FEBRUARY 3, 1996

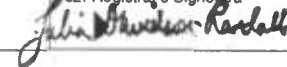
30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

JOSEPH KAPLAN 18111 Prince Philip Dr. OLNEY, MD 20832

31. Date filed (Month, Day, Year)

FEB 05 1996

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

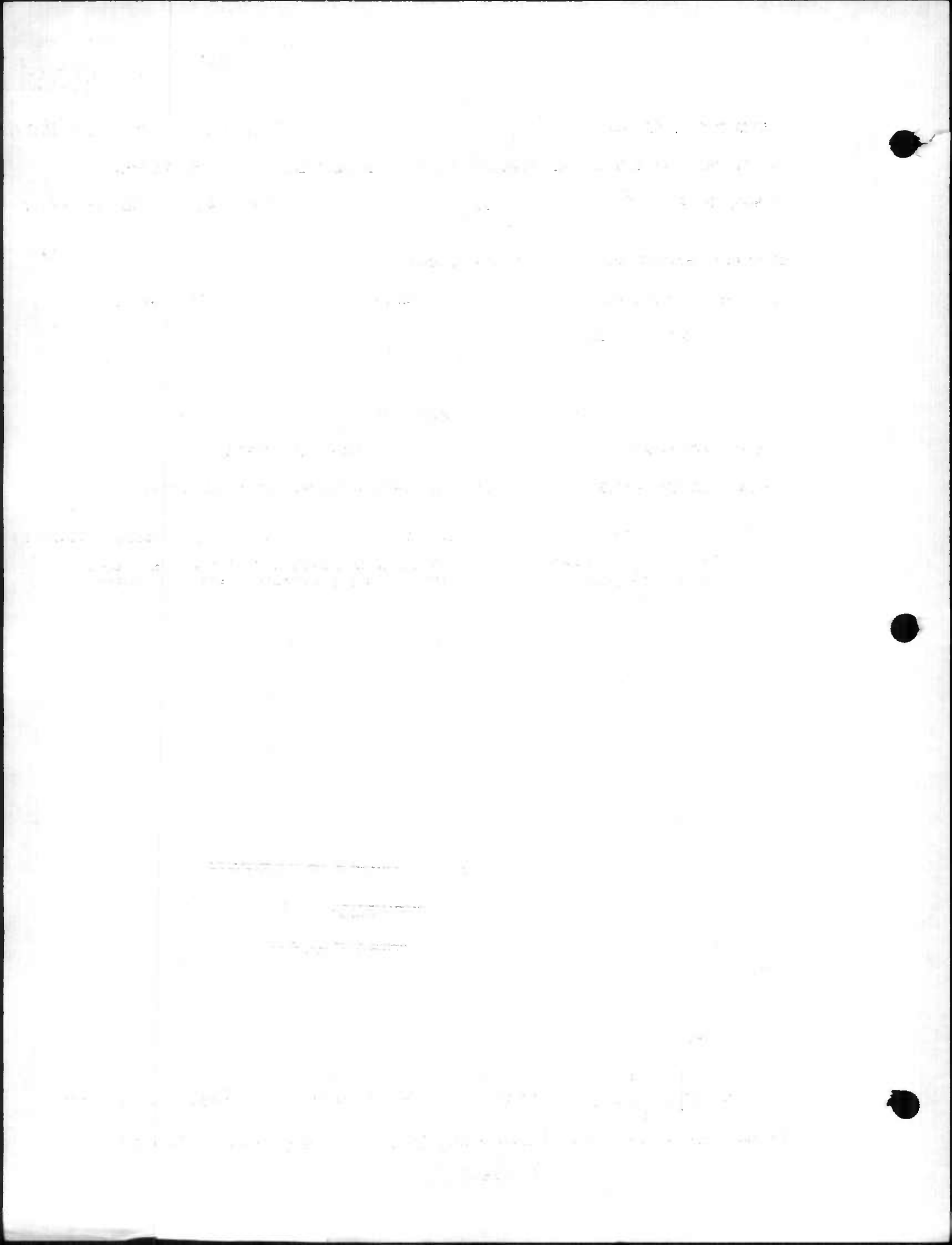
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Amended #23, 2/12/96, JW, Montgomery County  
Amended #31, 2/8/96, MRT, Montgomery County

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04980

|   |  |  |  |   |  |  |  |   |  |
|---|--|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Jose Gonzalez</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>February 5, 1996</b>   |  | 3. TIME OF DEATH<br><b>9:18 P M</b>  |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>338-24-0155</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>78</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Sept. 15, 1917</b>   |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Mexico</b>               |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Holy Cross Hospital</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Silver Spring</b>   |  |  | 9c. COUNTY OF DEATH<br><b>Montgomery</b> |   |  |
| RESIDENCE OF DECEDENT   |  |  |  | 10c. CITY, TOWN OR LOCATION<br><b>Silver Spring</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |   |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Montgomery</b>   |  | 10f. ZIP CODE<br><b>20902</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |   |  |
| 10e. STREET AND NUMBER<br><b>2021 Cascade Road</b>  |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES            |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO Specify: <b>Mexican</b> |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>   |  | 15b. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Physician</b>   |  | 16. KIND OF BUSINESS/INDUSTRY<br><b>Medical</b>   |  |  |  |   |  |
| 15a. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>College (1-4 or 5+)</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Physician</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Medical</b>  |  |  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Jose Gonzalez</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Maria Mora</b>  |  |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Helen M. Gonzalez</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2021 Cascade Road Silver Spring, Maryland 20902</b> |  |  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Gate of Heaven Cemetery 2/9/96</b>   |  | 20c. LOCATION — City or Town, State<br><b>Silver Spring, Maryland</b>   |  |  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Francis J. Collins Funeral Home, Inc.<br/>500 University Blvd., W. Sil. Spr., MD 20901</b>                       |  |  |  |   |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Heart Disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><br>b. <b>Cardiac Arrhythmia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>c. <b>Atherosclerotic Heart Disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>d.<br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b> |  |  |  |   |  |  |  | Approximate Interval Between Onset and Death<br><b>chronic</b>          |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  |  |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  | 28d. DESCRIBE NOW INJURY OCCURRED                                       |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Robert G. Finkel MD</b>   |  | 29c. LICENSE NUMBER<br><b>D43414</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>February 6, 1996</b>          |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Robert G. Finkel MD 1106 Spring Street Silver Spring MD</b>   |  |  |  |   |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 08 1996</b>   |  | 32. REGISTRAR'S SIGNATURE<br>  |  |   |  |  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR   |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 96 04981  |  |   |  |
|--|--|--|--|---|--|--|--|---|--|---|--|
| CERTIFICATE OF DEATH   |  |  |  | REG. NO.  |  |  |  |   |  |   |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>KENNETH WARE HARDING, SR.</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>February 7 1996</b>  |  |  |  | 3. TIME OF DEATH<br><b>1:40 P M</b>   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>224-38-2710</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>64 YRS.</b>  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Aug 16, 1931</b>                       |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Virginia</b>   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Memorial Hospital</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Cumberland</b>  |  |  |  | 9c. COUNTY OF DEATH<br><b>Allegany</b>  |  |   |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Garrett</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Friendsville</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO       |  |   |  |
| 10e. STREET AND NUMBER<br><b>34 Park St.</b>   |  |  |  | 10f. ZIP CODE<br><b>21531</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>white</b>                            |  |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>8 th</b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Carpenter</b>  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Construction</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Emerson O. Harding</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Naomi L. Whitaker</b>   |  |  |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Loretta M. Harding</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P.O. Box 141, 34 Park ST., Friendsville, MD 21531</b>   |  |  |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Harding Cemetery, Feb. 10, 1996</b>                    |  |   |  | DATE<br><b>Feb. 10, 1996</b>   |  | 20c. LOCATION — City or Town, State<br><b>Friendsville, MD</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Newman Funeral Homes, P.A., P.O. Box 275<br/>179 Miller St., Grantsville, MD 21536</b>   |  |  |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b><br><b>a. Septic Shock</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. Perforated Duodenal Ulcer</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c. Advanced Small Cell Carcinoma Lung</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d.</b><br>Approximate Interval Between Onset and Death<br><b>3 Days</b><br><b>4 Days</b><br><b>6/1995</b> |  |  |  |   |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>   |  |  |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><br><b>MD</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D 23371</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>Jan, 8, 96</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Qamar Zaman M.D. 625 Kent Ave. Suite 102 Cumberland MD 21502</b>   |  |  |  |   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 14 1996</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |  |  |   |  |   |  |





1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04982

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Richard Lee Hershberger   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>Feb. 9, 1996   |  | 3. TIME OF DEATH<br>5:00 A. M  |  |
| 4. SOCIAL SECURITY NUMBER<br>215-26-9400  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>66 YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>Dec. 15, 1929   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>Egle Nursing Home  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Lonaconing  |  |
| 9c. COUNTY OF DEATH<br>Allegany   |  |  |  | 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Allegany  |  |
| 10c. CITY, TOWN OR LOCATION<br>Lonaconing   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br>94 Jackson Street  |  |
| 10f. ZIP CODE<br>21539  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE YEAR OR DATES<br>1948-1950  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>White  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Labor  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Street Dept.   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Leland R. Hershberger  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Ellen Mae Moore   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Joan L. Hershberger   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>94 Jackson St., Lonaconing, Md. 21539   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Mt. View Cemetery Feb. 12, 1996   |  | 20c. LOCATION — City or Town, State<br>Moscow Mills, Md.   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Eichhorn-McKenzie Funeral Home<br>Lonaconing, Md. 21539  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Myelodysplastic Syndrome<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |  |  | Approximate Interval Between Onset and Death<br>6mo.   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |  |  | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Thomas J. Devlin MD  |  |  |  | 29c. LICENSE NUMBER<br>D21488  |  | 29d. DATE SIGNED (Month, Day, Year)<br>2-11-96   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Thomas J. Devlin MD, 20 Douglas Ave., Lonaconing, Md 21539   |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>FEB 12 1996  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

7  
NLS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



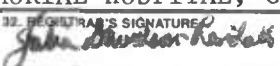
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04983

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>WILLIAM Jesse HEDRICK</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>FEBRUARY</b> DAY <b>4</b> YEAR <b>1996</b>  |  | 3. TIME OF DEATH<br><b>6:45 A M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>217-10-6505</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>84</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Aug. 25, 1911</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>W Va.</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Memorial Hospital</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Cumberland</b>   |  |
| 9c. COUNTY OF DEATH<br><b>Allegany</b>  |  |  |  | 10a. STATE<br><b>Md.</b>   |  | 10b. COUNTY<br><b>Allegany</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Cumberland</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>746 Maryland Ave.</b>   |  |
| 10f. ZIP CODE<br><b>21502</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 8</b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Machinist</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Railroad</b>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William Strite Hedrick</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Betty Jane Nelson</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>William L. Hedrick</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>13502 New Oakland Dr. N.E. Cumberland, Md. 21502</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Rest Lawn Memorial Gdns. 2/7/96</b>  |  | 20c. LOCATION — City or Town, State<br><b>LaVale, Md.</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Merritt-Adams Funeral Home<br/>404 Decatur St. Cumberland, Md. 21502</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Lannaecis Cirrhosis with Hepatic Eucephalopathy and Refractory Secites</b>  |  |  |  |  |  |  |  |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  |  |  |  |  |  |  |
| b. DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Esophageal Variceal Bleed</b>  |  |  |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |  |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  |  |  |  |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  |
| 29c. LICENSE NUMBER<br><b>D 35481</b>   |  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>2/5/96</b>   |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>MARK SAGIN M.D., MEMORIAL HOSPITAL, CUMBERLAND, MD 21502</b>                         |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 06 1996</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR  |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 96 04984  |  |  |  |
|--|--|--|--|---|--|---|--|---|--|--|--|
| CERTIFICATE OF DEATH   |  |  |  | REG. NO.  |  |   |  |   |  |  |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ERNEST GREENFIELD HOLLAND</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>2</b> DAY <b>6</b> YEAR <b>96</b>  |  |   |  | 3. TIME OF DEATH<br><b>1:54 P M</b>   |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>219-01-9490</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>80</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>11/5/15</b>                                       |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>MD</b>   |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Atlantic General Hospital</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Berlin</b>  |  |   |  | 9c. COUNTY OF DEATH<br><b>Worcester</b>   |  |  |  |
| 10a. STATE<br><b>MD</b>  |  |  |  | 10b. COUNTY<br><b>Worcester</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Berlin</b>  |  |   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br><b>300 S. Main St.</b>   |  |  |  | 10f. ZIP CODE<br><b>21811</b>   |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>white</b>                               |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>5+</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Educator</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Education</b>  |  |   |  |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Lester Marvin Holland</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Elizabeth Casper</b>  |  |   |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Nancy Ruth Holland</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>300 S. Main St. Berlin, MD 21811</b>  |  |   |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Evergreen Cemetery 2/10/96 Berlin, MD</b>  |  | 20c. LOCATION — City or Town, State   |  |   |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Burbage Funeral Home<br/>108 Williams St. Berlin, MD 21811</b>   |  |   |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Acute myocardial Infarction</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. Congestive heart failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d.</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |   |  | Approximate interval between Onset and Death<br><b>hours</b>  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  |   |  |   |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |   |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>2/6/96</b>  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED<br><b>cardiac arrest at home</b>                                    |  |  |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i> <b>MD</b>  |  |   |  | 29c. LICENSE NUMBER<br><b>D47676</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>2/6/96</b>  |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Bsher Touleimat, MD 9733 Healthway Dr. Berlin, MD 21811</b>  |  |  |  |   |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 07 1996</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |   |  |   |  |  |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04985

|  |  |  |   |  |  |  |   |  |
|--|--|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>JOHN JOSEPH HEALEY</b>  |  |   |  | 2. Date of Death<br>Month Day Year<br><b>February 3, 1996</b>  |  | 3. Time of Death<br><b>10:48 am</b>                                     |  |
|  | 4e. Facility Name (If not institution, give street and number)<br><b>Prince George's Medical Center</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Cheverly</b>  |  | 4c. County of Death<br><b>Prince George's</b>                           |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>200-22-2532</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>65</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Nov. 25, 1930</b>             |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>  |  | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Prince George's</b>  |  | 10c. City, Town or Location<br><b>Riverdale</b>                         |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 10e. Street and Number<br><b>6000 Madison Street</b>  |  | 10f. Zip Code<br><b>20737</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                          |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> Collage (1-4or 5+) <b></b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Clerk</b>                         |  | 16b. Kind of Business/Industry<br><b>Post Office</b>   |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>John E. Healey</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Margaret Manley</b>  |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mary Healey / Spouse</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6000 Madison Street, Riverdale, Maryland 20737</b>                                       |  |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Fort Lincoln Cemetery 02/06/96</b>                                   |  | 20c. Location - City or Town, State<br><b>Brentwood, Maryland</b>  |  |   |  |
|  | 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>Francis Gasch's Sons Funeral Home, P.A.<br/>4739 Baltimore Avenue, Hyattsville, MD 20781</b>  |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Myocardial Infarction</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. {</b><br><b>c. {</b><br><b>d. {</b> |  |   |  |  |  |   |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |  |  |  |   |  |
|  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   |  |  |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   |  |  |  |   |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |  |   |  |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  |  |   |  |  |  |   |  |
| 28a. Date of Injury (Month, Day Year)<br><b>28b. Time of Injury M</b><br><b>28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</b><br><b>28d. Describe how Injury occurred</b><br><b>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)</b><br><b>28f. Location (Street and Number or Rural Route Number, City or Town, State)</b>                 |  |  |   |  |  |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |  |  |  |   |  |
| 29b. Signature and title of certifier<br>   |  |  |   |  |  |  |   |  |
| 29c. License number<br><b>D26287</b>   |  |  |   |  |  |  |   |  |
| 29d. Date signed (Month, Day, Year)<br><b>2/3/96</b>   |  |  |   |  |  |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Michael Berard, M.D. 7305 Baltimore Avenue, Suite 107, College Park, MD 20740</b>   |  |  |   |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 07 1996</b>  |  |  |   |  |  |  |   |  |
| 32. Registrar's Signature<br>   |  |  |   |  |  |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

28246 241



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 96 04986

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Amir Hassan

2. Date of Death  
Month Day Year  
February 3, 1996  
3:40 am

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

12604 Sholton Drive

4b. City, Town, or Location of Death

Upper Marlboro

4c. County of Death

Prince Georges

5. Social Security Number

578-56-3074

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

51

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

June 15, 1944

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince Georges

10c. City, Town or Location

Upper Marlboro, Maryland

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

12604 Sholton Street

10f. Zip Code

20772

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No  
If Yes, Give Year or Dates: 1962-2/64

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4or 5+)  
4

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

General Contractor

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

John K. Branch

18. Mother's Name (First, Middle, Maiden Surname)

Harriet Thomas

19a. Informant's Name/Relationship (Type, Print)

Karima Hassan/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12604 Shelton Street Upper Marlboro, Maryland 20772

20a. Method of Disposition

☐ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Harmony Memorial

Data

2-8-96

20c. Location - City or Town, State

Landover, Maryland

21. Signature of Funeral Service Licensee

*Alex S. Pope*

22. Name and Address of Facility

Alexander S. Pope Funeral Homes

5538 Marlboro Pike Forestville, MD. 20747

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

HEPATIC CIRRHOSIS

a. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

Hospital:

☐ Inpatient

☐ ER/Outpatient

☐ DOA

Other:

☐ Nursing Home

☒ Residence

☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Augusto P. Rodriguez*

29c. License number

021230

29d. Date signed (Month, Day, Year)

February 4, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Augusto P. Rodriguez, 5009 Rayburn Ct. Sp. Md 20748

31. Date filed (Month, Day, Year)

FEB 07 1996

32. Registrar's Signature

*John Anderson*

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 5056.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

[illegible]

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04987

5 0/5

DIVISION OF VITAL RECORDS, P.O. BOX 687600 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ROZELLER HAILEY</b>  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JANUARY 31 1996</b>   |  | 3. TIME OF DEATH<br><b>10:49 PM</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>234-56-2234</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>78</b> YRS.   |  |
| 7. DATE OF BIRTH (Month, Day, Year)<br><b>April 3, 1917</b>   |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Peachland, NC</b>   |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Southern Maryland Hospital</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Chinton</b>  |  | 9c. COUNTY OF DEATH<br><b>Prince Georges</b>   |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Prince Georges</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Upper Marlboro, Maryland</b>   |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>12905 Lakeston Court</b>  |  | 10f. ZIP CODE<br><b>20774</b>  |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  |  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b></b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Domestic</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Private</b>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Spencer Ledbetter</b>   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Lou Chambers</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Doris Hawkins</b>  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>12905 Lakeston Court Upper Marlboro, MD. 20774</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery)<br><b>Lincoln Memorial 2/6</b>   |  | 20c. LOCATION — City or Town, State<br><b>Suitland, MD.</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Alexander S. Pope Jr.</i>   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Alexander S. Pope Funeral Homes<br/>5538 Mariboro Pike Forestville, MD 20747</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Respiratory failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>Sepsis shock, GI Bleed</b><br><b>COPD</b><br><b>large Bowel pseudoobstruction</b> |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Renal insufficiency, Anemia, CHF, IDDM, HxN, Bronchopneumonia</b><br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Valery Mathew</i>   |  | 29c. LICENSE NUMBER<br><b>D45435</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>2/1/96</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>VARKEY MATHEW M.D. SOUTHERN MARYLAND HOSPITAL</b>   |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>2/11 FEB 07 1996</b>  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Andrew Raskell</i>  |  |  |  |

1972-73

1972-73 1973-74

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04988

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Isaiah Hawkins Jr.  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>January 28 1996   |  | 3. TIME OF DEATH<br>12:30a <sup>m</sup>   |  |
| 4. SOCIAL SECURITY NUMBER<br>577-26-2188  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>85 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>Oct 8, 1910   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Southern Maryland Hospital center Clinton   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Clinton, Maryland  |  | 9c. COUNTY OF DEATH<br>Prince Georges   |  |
| 10a. STATE<br>Maryland  |  | 10b. COUNTY<br>Prince Georges   |  | 10c. CITY, TOWN OR LOCATION<br>Clinton, Maryland  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO               |  |
| 10e. STREET AND NUMBER<br>9211 Stuart Lane  |  |   |  | 10f. ZIP CODE<br>20735  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>United States  |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: Black  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 0 College (1-4 or 5+) 0   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>None / Disabled  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>N/A   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Isaiah Hawkins SR  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Rebecca Young  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Louise White  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>113 11th Street NE, Washington, DC 20002   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Metropolitan Crematory 1/31/96   |  | 20c. LOCATION — City or Town, State<br>Alexandria, VA   |  | 22. NAME AND ADDRESS OF FACILITY<br>Alexander S. Pope Funeral Home<br>2617 Pennsylvania Avenue SE, Washington, DC |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Alexander S. Pope Jr</i>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>Alexander S. Pope Funeral Home<br>2617 Pennsylvania Avenue SE, Washington, DC   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>ACUTE RENAL FAILURE</i><br>a. DUE TO (OR AS A CONSEQUENCE OF): <i>ASCN</i><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |   |  |   |  | Approximate interval Between Onset and Death<br><i>wks</i><br><i>yr</i>   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>PANHYPOSPITITARIUM</i><br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO         |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                              |  |
|   |  | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>   |  | 29c. LICENSE NUMBER<br>D19431   |  | 29d. DATE SIGNED (Month, Day, Year)<br>1/28/96  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Frank M. Jagan M.D. 61880xaw Hill Rd #601 Oxaw Hill MD   |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>FEB 07 1996  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1000 10 837

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1 - FOR STATE REGISTRAR   |  |  |   | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 96 04989  |  |
|---|--|--|---|---|--|---|--|---|--|
| CERTIFICATE OF DEATH  |  |  |   | REG. NO.  |  |   |  |   |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br>THEODORE R. HORNE   |  |  |   | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>January 30, 1996  |  | 3. TIME OF DEATH<br>2:50 A M  |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br>578-24-6069  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br>87 YRS. | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>Nov. 24, 1910   | 8. BIRTHPLACE (State or Foreign Country)<br>North Carolina |   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>GREENBELT NURSING HOME  |  |  |   | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Greenbelt  |  | 9c. COUNTY OF DEATH<br>Prince Georges   |  |   |  |
| 10a. STATE<br>D.C.  |  | 10b. COUNTY  |   | 10c. CITY, TOWN OR LOCATION<br>Washington, D.C.   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |   |  |
| 10e. STREET AND NUMBER<br>409 Xenia Street, S.E.  |  |  |   | 10f. ZIP CODE<br>20032  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  |   |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |   | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>Black                             |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12<br>College (1-4 or 5+)   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Federal Protective Office.  |   | 16b. KIND OF BUSINESS/INDUSTRY<br>U.S. GOVT.<br>C.I.A.  |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Christopher C. Horne   |  |  |   | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Cora White   |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Florence A. Pogue   |  |  |   | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>409 Xenia Street, SE, Washington, D.C. 20032   |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Metropolitan Crematory 2/5/96   |   | 20c. LOCATION — City or Town, State<br>Alexandria, VA   |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>J. P. Marshall   |  |  |   | 22. NAME AND ADDRESS OF FACILITY<br>Marshall's Funeral Home, Inc.<br>4308 Suitland Rd., Suitland, MD 20746  |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Aspiration<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. Neurogenic dysphagic<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. Organic Brain Syndrome<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Approximate Interval Between Onset and Death<br>Days<br>Months<br>Years |  |  |   |   |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>GASTROESOPHAGEAL REFLUX   |  |  |   |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |   |   |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |   | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
|   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |   |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                    |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |   |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Norton Elson MD  |  |  |   | 29c. LICENSE NUMBER<br>P20362   |  | 29d. DATE SIGNED (Month, Day, Year)<br>JAN 31, 1996   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>NORTON ELSON 6525 Belcrest Rd Hyattsville, MD 20782  |  |  |   |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>FEB 05 1996  |  |  |   | 32. REGISTRAR'S SIGNATURE<br>John Hudson Carroll  |  |   |  |   |  |

1947

1947



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

96-440-510

FILM G-733 3/4/96 t.t State of Maryland / Department of Health and Mental Hygiene

CIP

ITEMS: 23 PART I, 27, PER MEO

## Certificate of Death

Reg. No.

96 01990

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LORI

HUNTER

2. Date of Death  
Month Day Year

JANUARY 30, 1996

3. Time of Death  
7:00AM

4a. Facility Name (If not institution, give street and number)

8803 CANBERRA DRIVE

4b. City, Town, or Location of Death

CLINTON

4c. County of Death

PRINCE GEORGES

Funeral  
Director

5. Social Security Number

579-50-4818

6. Sex  
1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

33

If Under 1 Year  
Months DaysIf Under 24 Hrs.  
Hours Min.8. Date of Birth  
(Month, Day, Year)

6-4-62

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Md..

10b. County

Prince Georges

10c. City, Town or Location

Fairmont Heights

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6113 Kolb Street

10f. Zip Code

20743

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12th

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Unemployed

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

Thomas C. Hunter

18. Mother's Name (First, Middle, Maiden Surname)

Paulette West

19a. Informant's Name/Relationship (Type, Print)

Stephanie Hunter/ Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6113 Kolb St., Fairmont Hghts., Md. 20743

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Harmony Memorial Park

Date

2/6/96

20c. Location - City or Town, State

Landover, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Robert G. Mason Funeral Home

1661 Good Hope Rd. S.E. WDC 20020

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
stroke, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

SEIZURE DISORDER

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

JANUARY 31, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David R Fowler 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

FEB 08 1996

32. Registrar's Signature

John Anderson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
50505.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

10-2-20

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04991

|  |  |   |  |  |  |  |                                       |  |
|--|--|---|--|--|--|--|---------------------------------------|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>RALPH A. HOLMES Jr.                              |   |  |  | 2. Date of Death<br>Month Day Year<br>FEBRUARY 5, 1996 |  | 3. Time of Death<br>0030AM            |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>UNIVERSITY HOSPITAL S.T.U. |   |  |  | 4b. City, Town, or Location of Death<br>BALTIMORE CITY |  | 4c. County of Death<br>Baltimore City |  |
| Funeral<br>Director  | 5. Social Security Number<br>216-04-0436   |   | 8. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (in yrs. last birthday)<br>22 Yrs.              |  | If Under 1 Year<br>Months Days        |  |
|  |  |   |  |  |  |  | If Under 24 Hrs.<br>Hours Min.        |  |
|  |  | 6. Date of Birth (Month, Day, Year)<br>Nov. 1, 1973   |  | 9. Birthplace (State or Foreign Country)<br>Washington, D.C.   |  |  |                                       |  |
| Usual Residence of Decedent  |  |   |  |  |  |  |                                       |  |
| 10a. State<br>Maryland   |  | 10b. County<br>Prince Georges   |  | 10c. City, Town or Location<br>Hyattsville   |  |  |                                       | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| 10e. Street and Number<br>3916 Warner Avenue   |  |   |  | 10f. Zip Code<br>20784   |  | 10g. Citizen of What Country?<br>Prince George's   |                                       |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: Black   |                                       |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 Collega (1-4or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Car Salesman  |  | 16b. Kind of Business/Industry<br>Private  |                                       |  |
| 17. Father's Name (First, Middle, Last)<br>Ralph A. Holmes Sr.   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Ida McCoy   |  |  |                                       |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Ida M. Hiller - Mother   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3916 Warner Avenue, Hyattsville, Maryland 20784   |  |  |                                       |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Harmony Memorial Park   |  | 20c. Location - City or Town, State<br>Landover, Maryland  |  | 20d. Date<br>2/10/96   |                                       |  |
| 21. Signature of Funeral Service Licensee<br>John T. Stewart III   |  |   |  | 22. Name and Address of Facility<br>STEWART FUNERAL HOME, Inc.<br>4001 Benning Road, N. E., Washington, D. C.  |  |  |                                       |  |
| 23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Head Injuries<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |  |  |                                       |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |                                       |  |
|  |  |   |  |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |                                       |  |
|  |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes <input type="checkbox"/> No  |                                       |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |                                       |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br>2 <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br>3 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)<br>2-4-96  |  | 28b. Time of Injury<br>UNK M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |                                       | 28d. Describe how injury occurred<br>Driver in auto accident                                   |
|  |  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>STREET  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>7331 CARDOVEL RD   |  |  |                                       |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. Signature and title of certifier<br>David Locke MD   |  | 29c. License number<br>O.C.M.E.  |  | 29d. Date signed (Month, Day, Year)<br>FEBRUARY 05, 1996   |                                       |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>J. ARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201   |  |   |  |  |  |  |                                       |  |
| 31. Date filed (Month, Day, Year)<br>FEB 09 1996   |  | 32. Registrar's Signature<br>John Anderson  |  |  |  |  |                                       |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Amended #9c, MRT, 2/7/96, Montgomery County

1 -  
FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04992

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>DOROTHY MARIE HUMPHREY</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>FEB.</b> DAY <b>2</b> YEAR <b>1996</b>   |  | 3. TIME OF DEATH<br><b>0710</b> A. M.  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>220-26-2572</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>76</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Dec. 9, 1919</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Virginia</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>7 SPRUCE CT.</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BERLIN</b>   |  |
| 9c. COUNTY OF DEATH<br><b>USA</b>   |  |  |  | 10a. STATE<br><b>MD.</b>  |  | 10b. COUNTY<br><b>WORCESTER</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>BERLIN</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>7 SPRUCE CT.</b>  |  |
| 10f. ZIP CODE<br><b>21811</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  |  |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |  |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>Technician</b>  |  |  |  |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Technician</b>   |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>United States Government</b>   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Q.L. Tutwiler</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Lydia Fultz</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Bryan Humphrey</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4511 Wicomico Avenue Beltsville, Maryland 20705</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Port Lincoln Cemetery 2/5/1996</b>  |  | 20c. LOCATION — City or Town, State<br><b>Brentwood, Maryland</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Donald V. Borgwardt</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Donald V. Borgwardt Funeral Home, P.A.<br/>4400 Powder Mill Rd. Beltsville, Md. 20705</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Ovarian Cancer with metastasis</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. <b>9 months</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Bruce Green, MD</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D-35764</b>   |  | 29d. DATE SIGNED (Month/Day/Year)<br><b>2/2/96</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Bruce Green, MD 1001 Philadelphia Ave. Ocean City, Md. 21842</b>  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 07 1996</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>John Davidson Randall</b>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

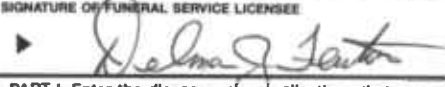

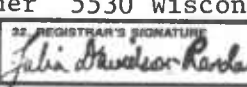
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Henry Victor Hartjens  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>January 30, 1996  |  | 3. TIME OF DEATH<br>8:45 A.M.  |  |
| 4. SOCIAL SECURITY NUMBER<br>043-03-1314   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>88 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>Feb. 16, 1907   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>New York   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>Manor Care-Bethesda   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Chevy Chase   |  |
| 9c. COUNTY OF DEATH<br>Montgomery  |  |  |  | 10a. STATE<br>Maryland  |  | 10b. COUNTY<br>Montgomery  |  |
| 10c. CITY, TOWN OR LOCATION<br>Kensington  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br>3910 Warner Street   |  |
| 10f. ZIP CODE<br>20895   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>United States  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>World War II   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 4 College (1-4 or 5+)   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Salesman  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Housewares   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Henry Gerhardt Hartjens   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Mary Isabel Spies Regina Spies   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Peter G. Hartjens  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3910 Warner Street Kensington, Maryland 20895  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Montgomery Crematorium, Inc. January 31, 1996  |  | 20c. LOCATION — City or Town, State<br>Bethesda, Maryland  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br> M00202   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Robert A. Pumphrey Funeral Home/<br>Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Bronchopneumonia<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. Parkinson's Disease<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. _____<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. _____<br>Approximate interval between Onset and Death<br>Days<br>Months |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DQA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide<br>3 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  |  |  | 29c. LICENSE NUMBER<br>D33357   |  | 29d. DATE SIGNED (Month, Day, Year)<br>1/30/96   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Lee Jonathan Musher 5530 Wisconsin Avenue Chevy Chase, Maryland 20815   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>FEB 06 1996   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 04994

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Charlotte Ann Hanson</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 28, 1996</b>   |  | 3. TIME OF DEATH<br><b>5:05 P.</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>457-48-8715</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>63</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>October 27, 1932</b>                              |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>MONTGOMERY GENERAL HOSPITAL</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>OLNEY</b>   |  | 9c. COUNTY OF DEATH<br><b>MONTGOMERY</b>  |  |
| 10a. STATE<br><b>Maryland</b>  |  |  |  | 10b. COUNTY<br><b>Montgomery</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Rockville</b>   |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  | 10e. STREET AND NUMBER<br><b>15228 Manor Lake Drive</b>   |  |   |  |
| 10f. ZIP CODE<br><b>20853</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>1</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Housewife</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Own Home</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Lelon Bryant Sanders</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Annie Garrett</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Rodney Louis Hanson</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>15228 Manor Lake Drive, Rockville, MD 20853</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>George Washington University Medical Center</b>  |  | DATE<br><b>1/29/96</b>  |  | 20c. LOCATION — City or Town, State<br><b>Washington, DC</b>                                |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Plutarco Rendon</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Columbia Mortuary Services, Inc.<br/>225 Missouri Avenue, NW, Washington, DC 20011</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  | a. <b>Pneumonia (Streptococcal)</b><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  | Approximate Interval Between Onset and Death<br><b>7 days</b>                               |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  | b. <b>COPD</b><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  | <b>10 years</b>   |  |
|  |  | c.<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |   |  |
|  |  | d.<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Bennett Morrison MD</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D 47682</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>January 28, 1996</b>                              |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Bennett Morrison 2901 Olney - Sandy Spring Rd, Olney, MD, 20832</b>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 06 1996</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>John Davidson Randall</b>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04995

|   |   |   |   |                               |  |  |   |  |  |  |   |                             |     |  |                                     |       |         |      |                  |
|---|---|---|---|-------------------------------|--|--|---|--|--|--|---|-----------------------------|-----|--|-------------------------------------|-------|---------|------|------------------|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Thelma Jean Hinton  |   |   |                               | 2. Date of Death<br>Month Day Year<br>Feb 04 96  |  |   |  | 3. Time of Death<br>3:10pm   |  |   |                             |     |  |                                     |       |         |      |                  |
|   | 4a. Facility Name (If not institution, give street and number)<br>8716 Bradford Road, #2  |   |   |                               | 4b. City, Town, or Location of Death<br>Silver Spring  |  |   |  | 4c. County of Death<br>Montgomery  |  |   |                             |     |  |                                     |       |         |      |                  |
| Funeral<br>Director   | 5. Social Security Number<br>237-92-9386  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |                               | 7. Age (in yrs. last birthday)<br>44 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>Sept. 4, 1951        |  | 9. Birthplace (State or Foreign Country)<br>North Carolina   |  |   |                             |     |  |                                     |       |         |      |                  |
|   | Usual Residence of Decedent   |   |   |                               |  |  |   |  |  |  |   |                             |     |  |                                     |       |         |      |                  |
| To Be Completed by Funeral Director   | 10a. State<br>Maryland  |   | 10b. County<br>Montgomery   |                               | 10c. City, Town or Location<br>Silver Spring   |  |   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |   |                             |     |  |                                     |       |         |      |                  |
|   | 10e. Street and Number<br>8716 Bradford Road, #2  |   |   |                               | 10f. Zip Code<br>20910   |  | 10g. Citizen of What Country?<br>United States              |  |  |  |   |                             |     |  |                                     |       |         |      |                  |
|   | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                               | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: Black   |  |  |   |                             |     |  |                                     |       |         |      |                  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 11 Collega (1-4or 5+) 11   |   |   |                               | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Food Service Worker   |  |   | 16b. Kind of Business/Industry<br>Fast Foods/ Hardee Systems   |  |  |   |                             |     |  |                                     |       |         |      |                  |
|   | 17. Father's Name (First, Middle, Last)<br>Johnny Webb  |   |   |                               | 18. Mother's Name (First, Middle, Maiden Surname)<br>Roberta Hinton  |  |   |  |  |  |   |                             |     |  |                                     |       |         |      |                  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br>Joyce Hinton Stone  |   |   |                               | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>Same as 10  |  |   |  |  |  |   |                             |     |  |                                     |       |         |      |                  |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Chesapeake Crematory  |                               | Date<br>2-11-96  |  | 20c. Location - City or Town, State<br>Beltsville, Maryland |  |  |  |   |                             |     |  |                                     |       |         |      |                  |
|   | 21. Signature of Funeral Service Licensee<br>Eileen H. Rapp   |   |   |                               | 22. Name and Address of Facility<br>Rapp Funeral Services, P. A.<br>933 Gist Avenue, Silver Spring, MD 20910   |  |   |  |  |  |   |                             |     |  |                                     |       |         |      |                  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |   |                               |  |  |   |  |  |  |   |                             |     |  |                                     |       |         |      |                  |
|   | <table border="1"> <tr> <td>Immediate Cause (Final disease or condition resulting in death)</td> <td>a. Peritonitis, spontaneous</td> <td>4d.</td> </tr> <tr> <td rowspan="3">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>b. End stage renal disease/dialysis</td> <td>5 mos</td> </tr> <tr> <td>c. AIDS</td> <td>2 WK</td> </tr> <tr> <td>d. HIV Infection</td> <td>16 mos</td> </tr> </table> |   |   |                               |  |  |   |  |  |  | Immediate Cause (Final disease or condition resulting in death) | a. Peritonitis, spontaneous | 4d. | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. End stage renal disease/dialysis | 5 mos | c. AIDS | 2 WK | d. HIV Infection |
| Immediate Cause (Final disease or condition resulting in death)   | a. Peritonitis, spontaneous   | 4d.   |   |                               |  |  |   |  |  |  |   |                             |     |  |                                     |       |         |      |                  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | b. End stage renal disease/dialysis   | 5 mos   |   |                               |  |  |   |  |  |  |   |                             |     |  |                                     |       |         |      |                  |
|   | c. AIDS   | 2 WK  |   |                               |  |  |   |  |  |  |   |                             |     |  |                                     |       |         |      |                  |
|   | d. HIV Infection  | 16 mos  |   |                               |  |  |   |  |  |  |   |                             |     |  |                                     |       |         |      |                  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Pericardial fluid; hypocoarctility<br>Repeated pulmonary infection<br>Refractory anemia despite Procrit   |   |   |   |                               |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |   |                             |     |  |                                     |       |         |      |                  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |   |                               |  |  |   |  |  |  |   |                             |     |  |                                     |       |         |      |                  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M      |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   | 28d. Describe how injury occurred  |  |  |   |                             |     |  |                                     |       |         |      |                  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br>Katherine Waldmann, M.D.   |   | 29c. License number<br>D08818 |  | 29d. Date signed (Month, Day, Year)<br>Feb 06, 1996                                  |   |  |  |  |   |                             |     |  |                                     |       |         |      |                  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Katherine Waldmann, MD 2000 Dennis Avenue Silver Spring, MD 20902   |   |   |   |                               |  |  |   |  |  |  |   |                             |     |  |                                     |       |         |      |                  |
| 31. Date filed (Month, Day, Year)<br>FEB 08 1996  |   | 32. Registrar's Signature<br>John Davidson Randall  |   |                               |  |  |   |  |  |  |   |                             |     |  |                                     |       |         |      |                  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



DHMH-16 Rev 1/89



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR  |                                  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  | 96 04997   |  |
|---|----------------------------------|---|--|--|--|
| CERTIFICATE OF DEATH  |                                  | REG. NO.  |  |  |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>PAUL A. L. HABER</b>   |                                  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>February 6 1996</b>  |  | 3. TIME OF DEATH<br><b>0945A</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>080-18-5584</b>   | 5. SEX<br><b>1</b> M <b>2</b> F  | 6. AGE (In yrs. last birthday)<br><b>75</b> YRS.  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>FEB. 14, 1920</b> | 8. BIRTHPLACE (State or Foreign Country)<br><b>NEW YORK</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>SHADY GROVE ADVENTIST HOSPITAL</b>   |                                  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>ROCKVILLE</b>   |  | 9c. COUNTY OF DEATH<br><b>MONTGOMERY</b>   |  |
| RESIDENCE OF DECEDENT   |                                  |   |  |  |  |
| 10a. STATE<br><b>MARYLAND</b>   | 10b. COUNTY<br><b>MONTGOMERY</b> | 10c. CITY, TOWN OR LOCATION<br><b>BETHESDA</b>  |  | 10d. INSIDE CITY LIMITS?<br><b>1</b> YES <b>2</b> NO   |  |
| 10e. STREET AND NUMBER<br><b>7501 HONEYWELL LANE</b>  |                                  | 10f. ZIP CODE<br><b>20814</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>UNITED STATES</b>  |  |
| 11. MARITAL STATUS<br><b>1</b> Never Married <b>2</b> Married<br><b>3</b> Widowed <b>4</b> Divorced   |                                  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> YES <b>2</b> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> YES <b>2</b> NO Specify: |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |                                  |   |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+) <b>5+</b>   |                                  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>GERONTOLOGIST</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>MEDICAL</b>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>BENJAMIN HABER</b>  |                                  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>GUSSIE SCHNURR</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>MARY HABER (WIFE)</b>  |                                  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7501 HONEYWELL LANE - BETHESDA, MARYLAND 20814</b>                              |  |  |  |
| 20a. METHOD OF DISPOSITION<br><b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State<br><b>4</b> Donation <b>5</b> Other (Specify)  |                                  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place)<br><b>MARYLAND VETERANS CEM. 2/8</b>   |  | 20c. LOCATION — City or Town, State<br><b>CHELTELHAM, MARYLAND</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>   |                                  | 22. NAME AND ADDRESS OF FACILITY<br><b>DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.<br/>1170 ROCKVILLE PIKE-ROCKVILLE, MD. 20852</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. CARDIAC ARREST OF RIGHT VENTRICLE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br><b>b. INFECTION WITH MYOCARDIAL INFARCTION</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br><b>c.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br><b>d.</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |                                  | Approximate Interval Between Onset and Death<br><b>6 hours</b><br><b>6 hours</b>  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Complete Heart Block</b><br><b>Room Fainting</b>   |                                  | 24a. WAS AN AUTOPSY PERFORMED?<br><b>1</b> YES <b>2</b> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1</b> YES <b>2</b> NO  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1</b> YES <b>2</b> NO  |                                  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA<br>OTHER: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br><b>1</b> Natural <b>5</b> Pending Investigation<br><b>2</b> Accident <b>3</b> Suicide <b>4</b> Homicide <b>6</b> Could not be determined   |                                  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>  |  |
| 28c. INJURY AT WORK?<br><b>1</b> YES <b>2</b> NO  |                                  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. CERTIFIER (Check only one)<br><b>1</b> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |                                  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>   |  | 29c. LICENSE NUMBER<br><b>041520</b>   |  |
| 29d. DATE SIGNED (Month, Day, Year)<br><b>February 6, 1996</b>  |                                  |   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>MARK MINOR 6410 ROCKWELL DRIVE BETHESDA MARYLAND</b>  |                                  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 08 1996</b>   |                                  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |  |  |





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 96 04998

|  |   |   |   |  |  |  |   |  |   |   |   |   |
|--|---|---|---|--|--|--|---|--|---|---|---|---|
| <b>Physician<br/>/Medical<br/>Examiner</b>   | 1. Decedent's Name (First, Middle, Last)<br><b>GERALDINE WETMORE HYATT</b>  |   |   |  |  |  | 2. Date of Death<br>Month Day Year<br><b>FEB 4, 1996</b>                                    |  | 3. Time of Death<br><b>4:10 pm</b>                          |   |   |   |
|  | 4a. Facility Name (If not Institution, give street and number)<br><b>CARRIAGE HILL, BETHESDA</b>  |   |   |  |  |  | 4b. City, Town, or Location of Death<br><b>BETHESDA</b>                                     |  | 4c. County of Death<br><b>MONTGOMERY</b>                    |   |   |   |
| <b>Funeral<br/>Director</b>  | 5. Social Security Number<br><b>258.42.7041</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>93</b> Yrs. |  | 8. Date of Birth (Month, Day, Year)<br><b>JAN. 30, 1903</b>                                 |  | 9. Birthplace (State or Foreign Country)<br><b>NEW YORK</b> |   |   |   |
|  | Usual Residence of Decedent   |   |   |  |  |  |   |  |   |   |   |   |
| 10a. State<br><b>MARYLAND</b>  |   | 10b. County<br><b>MONTGOMERY</b>  |   | 10c. City, Town or Location<br><b>BETHESDA</b>   |  |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |   |   |   |
| 10e. Street and Number<br><b>5216 SANGAMORE ROAD</b>   |   |   |   | 10f. Zip Code<br><b>20816</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   |  |   |   |   |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                     |  |   |   |   |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>+2</b> College (1-4 or 5+)   |   |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>OFFICE MANAGER</b>   |  |  | 16b. Kind of Business/Industry<br><b>ASSOCIATIONS</b>                                       |  |   |   |   |   |
| 17. Father's Name (First, Middle, Last)<br><b>WILLIAM O. WETMORE</b>   |   |   |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>VICTORIA JENNINGS</b>  |   |  |   |   |   |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>CORNELIA HYATT</b>  |   |   |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5216 SANGAMORE ROAD BETHESDA, MD. 20816</b>  |   |  |   |   |   |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>GATE OF HEAVEN CEMETERY</b>  |  |  | Date<br><b>2/9/96</b>  |   | 20c. Location - City or Town, State<br><b>SILVER SPRING, MD.</b>   |   |   |   |   |
| 21. Signature of Funeral Service Licensee<br>  |   |   |   |  |  | 22. Name and Address of Facility<br><b>JOSEPH GAWLER'S SONS<br/>5130 WI AVE NW WASHINGTON DC 20016</b>   |   |  |   |   |   |   |
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |   |   |  |  |  |   |  |   |   |   |   |
| <table border="0" style="width:100%;"> <tr> <td style="width:30%; vertical-align: top;">           Immediate Cause (Final disease or condition resulting in death)<br/><br/>           Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td style="width:60%; vertical-align: top;">           a. <b>Aspiration PNEUMONIA</b><br/>               Due to (or as a consequence of):<br/>           b. <b>ALZHEIMER'S Disease</b><br/>               Due to (or as a consequence of):<br/>           c. _____<br/>               Due to (or as a consequence of):<br/>           d. _____         </td> <td style="width:10%; vertical-align: top;">           Approximate Interval Between Onset and Death<br/><br/> <b>48 hours</b><br/><br/> <b>7 years</b> </td> </tr> </table> |   |   |   |  |  |  |   |  |   | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. <b>Aspiration PNEUMONIA</b><br>Due to (or as a consequence of):<br>b. <b>ALZHEIMER'S Disease</b><br>Due to (or as a consequence of):<br>c. _____<br>Due to (or as a consequence of):<br>d. _____ | Approximate Interval Between Onset and Death<br><br><b>48 hours</b><br><br><b>7 years</b> |
| Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | a. <b>Aspiration PNEUMONIA</b><br>Due to (or as a consequence of):<br>b. <b>ALZHEIMER'S Disease</b><br>Due to (or as a consequence of):<br>c. _____<br>Due to (or as a consequence of):<br>d. _____ | Approximate Interval Between Onset and Death<br><br><b>48 hours</b><br><br><b>7 years</b>   |   |  |  |  |   |  |   |   |   |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |   |   |   |   |
|  |   |   |   |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |   |   |   |
|  |   |   |   |  |  |  |   |  |   |   |   |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   | 28. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |   |   |   |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>                  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred                           |   |   |   |
|  |   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                |  |   |   |   |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |   |   |  |  |  |   |  |   |   |   |   |
| 29b. Signature and title of certifier<br>   |   |   |   |  |  | 29c. License number<br><b>DC 9991</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>2/5/96</b>   |   |   |   |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JOHN C. PERKINS 4910 MASS. AVE. N.W. #304 WASHINGTON D.C. 20016</b>   |   |   |   |  |  |  |   |  |   |   |   |   |
| 31. Date filed (Month, Day, Year)<br><b>FEB 07 1996</b>  |   |   | 32. Registrar's Signature<br>  |  |  |  |   |  |   |   |   |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 04999

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

William Edward Hanford

2. Date of Death

Month Day Year  
Jan. 27, 1996

3. Time of Death

8:45 P.M.

4a. Facility Name (If not institution, give street and number)

Fernwood Nursing Home

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

221-07-7480

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

87

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 9, 1908

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

4956 Sentinal Drive

10f. Zip Code

20816

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)  
5+16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

scientist/chemist

18b. Kind of Business/Industry

Olin Corp.

17. Father's Name (First, Middle, Last)

Thomas Cook Hanford

18. Mother's Name (First, Middle, Maiden Surname)

Irene Laing

19a. Informant's Name/Relationship (Type, Print)

William E. Hanford, Jr. (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5613 Overlea Rd., Bethesda, Md. 20816

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Riverview Cemetery Feb. 5, 96

Date

20c. Location - City or Town, State

Wilmington, Del.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DeVol Funeral Home  
2222 Wisconsin Ave., N.W., Wash., D.C. 2000723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. myocardial infarct

Due to (or as a consequence of):

b. atherosclerotic cardiovascular disease

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

hours

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

hip fracture, COPD, dementia

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☒ No25. Was case referred to medical  
examiner?☒ Yes ☐ No

28. Place of Death (Check only one)

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☐ Natural ☐ Pending  
Investigation  
☒ Accident ☐ Could not be  
determined  
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

Jan. 9, 96

28b. Time of Injury

7 P.M.

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how Injury occurred

fell

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

home

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

4956 Sentinal Dr., Bethesda

29a. Certifier  
(Check only  
one)☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D08546

29d. Date signed (Month, Day, Year)

February 2, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John Tauber, M.D., 8218 Wisconsin Avenue, #318, Bethesda, Md.

31. Date filed (Month, Day, Year)

FEB 06 1996

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 23b show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. DECEASED'S NAME (First, Middle, Last)   |  |   |                                | 2. DATE OF DEATH  |  |   |  | 3. TIME OF DEATH   |  |
|--|--|---|--------------------------------|---|--|---|--|--|--|
| ABE HANOPOLE   |  |   |                                | FEBRUARY 1 1996   |  |   |  | 1:20 PM  |  |
| 4. SOCIAL SECURITY NUMBER  |  | 5. SEX  | 6. AGE (In yrs. last birthday) | 7. DATE OF BIRTH  |  | 8. BIRTHPLACE (State or Foreign Country)                                |  |  |  |
| 578-30-6885  |  | 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  | 80 YRS.                        | Feb. 12, 1915   |  | New Jersey  |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)   |  |   |                                | 9b. CITY, TOWN OR LOCATION OF DEATH   |  |   |  | 9c. COUNTY OF DEATH  |  |
| Holy Cross Hospital  |  |   |                                | Silver Spring   |  |   |  | Montgomery   |  |
| RESIDENCE OF DECEASED  |  |   |                                |   |  |   |  |  |  |
| 10a. STATE   |  | 10b. COUNTY   |                                | 10c. CITY, TOWN OR LOCATION   |  | 10d. INSIDE CITY LIMITS?  |  |  |  |
| MD   |  | Montgomery  |                                | Silver Spring   |  | 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |  |  |
| 10e. STREET AND NUMBER   |  |   |                                | 10f. ZIP CODE   |  | 10g. CITIZEN OF WHAT COUNTRY?   |  |  |  |
| 13404 Dauphine Street  |  |   |                                | 20906   |  | U.S.A.  |  |  |  |
| 11. MARITAL STATUS   |  | 12. WAS DECEASED EVER IN U.S. ARMED FORCES?   |                                | 13. WAS DECEASED OF HISPANIC ORIGIN?  |  | 14. RACE — American Indian, Black, White, etc.                          |  |  |  |
| 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |                                | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>Specify:           |  | Specify: White  |  |  |  |
| 15. DECEASED'S EDUCATION<br>(Specify only highest grade completed)   |  | 16a. DECEASED'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)   |                                | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |  |  |
| Elementary/Secondary (0-12) 2  |  | College (1-4 or 5+)   |                                | Program Officer Government/Dept. of Defense   |  |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)  |  |   |                                | 18. MOTHER'S NAME (First, Middle, Maiden Surname)   |  |   |  |  |  |
| Max Hanopole   |  |   |                                | Sarah Edelstein   |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)   |  |   |                                | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |  |   |  |  |  |
| Esther Hanopole (Wife)   |  |   |                                | 13404 Dauphine St., Silver Spring, MD 20906   |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)   |                                | DATE  |  | 20c. LOCATION — City or Town, State                                     |  |  |  |
| 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | Judean Memorial Gardens   |                                | 2/4   |  | Olney, MD   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  |  |   |                                | 22. NAME AND ADDRESS OF FACILITY  |  |   |  |  |  |
|  |  |   |                                | Edward Sagel Funeral Direction<br>1091 Rockville Pike Rockville, MD 20852                     |  |   |  |  |  |
| 23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |                                |   |  |   |  | Approximate interval between Onset and Death                                 |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  |   |                                |   |  |   |  | 10 days  |  |
| Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  |   |                                |   |  |   |  | 4 wks.   |  |
| a. Respiratory failure   |  |   |                                |   |  |   |  | 4 wks.   |  |
| b. Toxic Megacolon   |  |   |                                |   |  |   |  |  |  |
| c. Colitis   |  |   |                                |   |  |   |  |  |  |
| d.   |  |   |                                |   |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |                                |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?   |  |
| Multiple Sclerosis   |  |   |                                |   |  |   |  | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                 |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>  |  |   |                                |   |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  |  |
|  |  |   |                                |   |  |   |  | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                 |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?   |  | 26. PLACE OF DEATH (Check only one)   |                                |   |  |   |  |  |  |
| 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                |   |  |   |  |  |  |
| 27. MANNER OF DEATH  |  | 28a. DATE OF INJURY   |                                | 28b. TIME OF INJURY   |  | 28c. INJURY AT WORK?  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |
| 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide |  | (Month, Day, Year)  |                                | M   |  | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO            |  |  |  |
|  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |                                |   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |  |
|  |  |   |                                |   |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)  |  |   |                                |   |  |   |  |  |  |
| 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |                                |   |  |   |  |  |  |
| 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |                                |   |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  |  |   |                                | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)                                     |  |  |  |
|  |  |   |                                | D37891  |  | FEBRUARY 1 1996   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  |  |   |                                |   |  |   |  |  |  |
| AMIT RAJVANSHI M.D. 121 Congressional Ln # 409 Rockville MD 20855  |  |   |                                |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)  |  |   |                                | 32. REGISTRAR'S SIGNATURE   |  |   |  |  |  |
| FEB 06 1996  |  |   |                                |   |  |   |  |  |  |

